ADMINISTERING HEALTH CENTRES: A SURVEY OF THE POLICY AND PRACTICE OF HEALTH DISTRICTS AND SINGLE DISTRICT AREAS IN ENGLAND

by

Gail Baker and John Bevan

MAY 1981

H.S.R.U. Report No. 44

HEALTH SERVICES RESEARCH UNIT
UNIVERSITY OF KENT AT CANTERBURY
CANTERBURY

ACKNOWLEDGEMENTS

We are most grateful to the district administrators, and area administrators of single district areas, and their staff, who responded so helpfully and readily to our enquiries, which, particularly in those districts or areas in the many health centres involved a considerable amount of work.

We thank Barbara Wall, who both supervised the coding of the questionnaires, and carried out the substantial and complex work of data processing.

Our thanks also to Linda McDonnell, who typed and prepared the report, with assistance from Shirley Woodward, Valerie Heap, Barbara Wall and Isabel Butler. Nita Watson, Tina Pullinger and Barbara Holland also undertook typing and clerical tasks in the earlier stages of the study; and Sue Clayton undertook coding.

We are grateful to our colleagues in the Health Services Research Unit who gave valuable comment and criticism on the draft of this Report, in particular Michael Warren, John Butler, Robin Dowie, Derek Duckworth, Rose Knight and David Perkins.

This study was supported by the Department of Health and Social Security for which we thank them.

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SUMMARY

The survey and response rates

This is the report of a survey addressed to all district administrators and administrators of single district areas in England in mid-1977 with the purpose of discovering what were the preferred policies and actual practices in these districts and areas concerning the administration of health centres. Ninety-four per cent of those approached responded and their answers covered a similar proportion of the health centres then functioning in England. Out of the 193 HD/SDAs for which a response was available, 23 did not have health centres in operation at the time so the results which follow are based on the 170 HD/SDAs responsible for at least one health centre and relate to a total of 710 health centres.

Systems within HD/SDAs* for administering health centres

One of two basic approaches appeared to be adopted in most cases; (1) the 'geographical' approach where the health centres were administered as part of a collection of both primary and acute hospital service facilities defined in geographical terms; (2) The 'community approach' where health centres in any HD/SDA or small locality were administered as part of a collection of predominantly 'community' services. The community approach was adopted in about 60 per cent of the HD/SDAs and the geographical approach by about 33 per cent, the remaining HD/SDAs adopted arrangements which could not be easily classified in general terms. (See pages 4 and 5).

The number of staff per centre stated to be responsible for their day-to-day administration

In about 75 per cent of the centres one person was named as having this responsibility (we refer to these as one person centres), for 19 per cent of the centres two persons were named (two person centres), and for 5 per cent, three persons were mentioned (three person centres) (page 17).

Types of staff responsible for the day-to-day administration of health centres

Among one person centres, the most common arrangement was to have an administrator (often but not necessarily titled health centre administrator) employed by the health authority and based at a health centre. Usually

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* i.e. Health district or single district area

this officer had responsibility for just a single centre but sometimes the responsibility extended to more than one centre and/or to clinics or a small hospital. In total 56 per cent of the one person centres were administered on a day-to-day basis by a health authority employed officer based locally either in that centre itself or in another centre whose raison d'etre was to administer that centre together with possibly other centres and premises. We will refer to such staff henceforth as 'Health Centre Administrators'. A further 14 per cent were administered by a health authority employee such as a clinic clerk or health visitor in addition to their other possibly primary duties. Six per cent of one person centres were administered by an employee of the general practitioners in the centre. Thus three-quarters of the one person centres were administered by someone based either at that health centre or another health centre; and the vast majority of those were health authority employees. The remaining quarter of the one person centres were administered by an officer employed by the health authority but not based in a health centre. This person might be a unit administrator based at a hospital or someone centrally based in terms of the health district or single district area such as a sector administrator, (pages 17 and 19).

Among the two and three person centres a wide variety of arrangements were found but two patterns recurred fairly frequently. The first was a combination of one or more staff based at the centre together with one or more general administrators based elsewhere than in a health centre, usually centrally; the second pattern was one of one or more centre based general administrative staff together with one or more functional officers such as a domestic services supervisor or nursing officer or community nurse who might or might not be based at the centre itself, (pages 18, 20, 21).

Preferences of HD/SDA respondents concerning day-to-day administration of health centres

Generally it appears that the arrangements in being at the centres of an HD/SDA were compatible with those preferred (often HD/SDAs found a number of alternatives equally acceptable) with two partial exceptions; (1) in a number of centres where at least one of the administrators involved in the day-to-day administration of health centres was general practitioner employed, this was not one of the arrangements indicated as preferred by the HD/SDA respondent; (2) in a number of cases where the only preferred arrangement was to have a central administrator such as a sector administrator

responsible for the day-to-day administration of the health centre, in fact some centres in the corresponding districts or areas were administered by local centre based staff, (page 6).

Administrative arrangements in relation to size of the health centre.

The size of the health centre, whether measured in terms of the general practitioners practising there or the 'complexity' of the centre (see page 47) as a whole as an organisation to be administered,seemed to have very little to do with the number of administrators stated to be responsible for its day-to-day running.

Among the one person centres, the larger the centre, the more likely it was to be administered by a 'health centre administrator'. Moreover the larger the health centre at least up to level of those of the order of a dozen doctors, the more likely it was that such an administrator would be on a relatively high salary grade such as GAA* or above. A probable reason for the fact that the association of salary grade of the health centre administrator with the size of centre 'weakened' in the case of the apparently very large centres is that some of these in effect served as branch surgeries for a substantial proportion of the general practitioners working from them and so were less substantial concentrations of primary health care activity that might at first appear, (pages 47-49).

Little or no evidence of association of salary grade of locally based administrators with size of health centres was found in the case of two and three person centres, (page 49).

Salary grades of locally based (i.e. in a health centre) staff with day-to-day administrative responsibilities for health centres

These staff were generally on the HCO or GAA grades with some on the CO grade and some a higher grades such as SAA. Generally speaking the salary levels of such local health centre based staff was lower in the case of two and three person centres than in one person centres. Also'health centre administrators' tended to be on a higher salary grade than locally based staff, for whom health centre administration was only a (possibly subsidiary) part of their function, (pages 22-27).

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* For explanation of abbreviations see Glossary at end of the Report.

In one person centres among 'health centre administrators' about a third of those with responsibility for just one health centre were on GAA or a higher grade, the remainder being almost all graded HCO. Among those who had responsibility for more than one centre and/or other premises predictably the proportion on the higher grades was greater. Locally based lay staff such as clinic clerks with the administration of a health centre as just one of their duties tended to be graded as HCO or CO, (pages 23-24).

Salary grades preferred by HD/SDA respondents for locally based staff for the administration of health centres

Generally these were compatible with those actually found in the corresponding HD/SDAs except that there was some suggestion that HCO might have been a more suitable grade for some of those on the CO grade (page 11). These results relate to the 119 HD/SDAs with 'health centre administrators' in post out of the 170 with health centres in operation. Generally speaking respondents from these HD/SDAs most often suggested the GAA grade as appropriate for 'health centre administrators' but also relatively often the grade of HCO. Other more and less senior grades were very seldom suggested. Of the HD/SDA respondents who gave criteria for deciding which salary grade was appropriate for a health centre administrator, most mentioned the size of the centre and the general extent of the services provided there; although a number expressly mentioned the number of general practitioners in the centre and the extent of the work done by the administrator in respect of clinics and other community services (page 11).

Career opportunities for 'health centre administrators'

Respondents from HD/SDAs with'health centre administrators' in post mostly thought there were career opportunities for such officers within the National Health Service beyond their present kind of posts. HD/SDAs with a community-type system for administering health centres within the district or area were rather more likely to see career opportunities beyond the health centre than were HD/SDAs with geographical systems (page 10).

Backgrounds thought appropriate for 'health centre administrators'

About a quarter of the HD/SDA respondents where such administrators were in post mentioned having or studying for IHSA qualifications. Clerical and secretarial backgrounds however were mentioned much more often than administrative or supervisory experience. Health service experience of

some kind not necessarily in general practice or community health was widely mentioned, (page 9).

Previous work experience of those responsible for the day-to-day administration of health centres

Relatively few, even among those with the title 'health centre administrator', (see page 36) had administrative or supervisory experience in a previous appointment.

Much more common was experience of a secretarial or clerical nature and/or experience as a receptionist. Roughly half of the staff based at centres with day-to-day responsibility for their administration had previous health services (including general practice) experience of some kind (page 37). Around a third had previous experience in local government, not necessarily in the health department (pages 39 and 40). Apart from previous work experience in the health services and/or local government, some of the officers were reported to have experience gained in other organisations in the private and public sectors. Of those responsible for day-to-day administration based in a centre, only about one-sixth had such experience. For more senior officers based centrally (that is not in a health centre) previous experience tended in the nature of things to be administrative or supervisory (page 35); and about a half had previous experience in local government and most of the rest experience in some (other) branch of the health services (pages 38 and 39).

Training thought appropriate for 'health centre administrators'

Respondents from HD/SDAs with such administrators in post mostly indicated that training was given to such officers either on appointment and/or at a later stage as in-service training. This training varied from visits to health centres and other parts of the health services to various kinds of management courses (pages 9 and 10).

Preferred arrangements for liaison between persons based in health centres responsible for day-to-day administration and other officers in the HD/SDA

About half the HD/SDA respondents preferred that persons in the health centre should contact both functional and administrative officers as appropriate and just over a third that liaison should be with an administrative officer only, that is to say not directly to functional officers (page 12).

Persons to whom those with the day-to-day responsibility for the administration of health centres were directly accountable.

Most of those based at health centres were accountable to a health authority employed officer, usually a lay administrator such as a sector administrator or a community services administrator in the case of one person centres; very seldom were they responsible to general practitioners or to a health centre house committee (pages 42 and 43). The situation was somewhat more complex in two and three person centres due to the greater involvement of officers with functional rather than general administrative responsibilities (pages 43 and 44).

Meetings in the HD/SDA attended by those responsible for day-to-day administration of health centres

About half the 'health centre administrators' attended at least one meeting with other health authority staff in the HD/SDA, relatively few of other staff with health centre administration responsibilities based in the centre did so (page 45).

Health centre house committees: existence of role of 'health centre administrator' therein

There was a health centre house committee in just over half of the one person centres, in a quarter of the two person centres and in one-in-six of the three person centres (page 46). In one person centres, 'health centre administrators' were almost all members of these committees and usually served as secretary. Other staff with responsibility for health centre administration were much less likely to be members or officers of such a committee. In two and three person centres, the local staff responsible for health centre administration were less likely to be members or officers of a health centre house committee.

Views of HD/SDA respondents on health centre house committees and their membership

Eighty per cent of the respondents from HD/SDAs considered that having a house committee in health centres was essential or desirable (page 12). HD/SDAs who favoured having health centre house committees were more likely to have them in their centres. As to membership preferred for such committees, HD/SDAs favoured having representatives from each general

medical practice on the committee rather than all general practitioners in the centre. Three-quarters thought that the'health centre administrator' if in post, was an essential member of the committee and about 60 per cent that a nurse based in the centre should serve on the committee. Respondents were evenly divided about a FPC or receptionist representative on the committee. A consumer representative was not popular,nearly half of the respondents being definitely against the idea. An administrative officer from the district or sector was generally thought desirable as a committee member, usually the sector administrator or a community services administrator was suggested. Other persons written in by the respondents as appropriate as members of health centre health committees were in order of popularity a dental officer, a community physician, and a chiropodist; a few mentioned social workers, (page 13).

Contribution by general practitioners to the cost of salaries of those responsible for the day-to-day administration of health centres: actual arrangements and preferences of HD/SDA respondents

In one person centres, about half the staff in question were paid for entirely by the health authority and the cost was shared between general practitioners and the health authority in some proportion or other for most of the remainder (page 28). Generally staff with the title clinic clerk were more usually paid by the health authority and the cost was shared in the case of those with the title secretary/receptionist. Health centre administrators, so titled, conformed to the overall pattern mentioned above. Broadly similar results were obtained for two and three person centres. Among the respondents from HD/SDAs with 'health centre administrators' in-post, about half preferred to pay the whole salary of those employed in a health centre for administration and almost the same number that the general practitioners should make some contribution.

Broadly speaking, the preferences of HD/SDA respondents conformed with actual practice in the centres in the HD/SDA (page 11).

Who employed the general practitioner's receptionist in a health centre: preferences of HD/SDA respondents and actual arrangements.

Forty per cent of the HD/SDA respondents preferred that the health authority be the employer of such receptionists. A similar percentage preferred that the general practitioner should employ staff themselves

and the rest did not have any preference. In the case of centres administered by HD/SDAs who preferred to employ the receptionist staff themselves, in two-thirds this was in fact the case. In health centres administered by HD/SDAs who preferred the general practitioners to employ receptionist staff, 87 per cent of the general practitioners did in fact employ their own staff (page 12).

HD/SDA respondents' comments on particular successes and difficulties in the health centre administration policies of their HD/SDA

Just over half the HD/SDAs commented on successes and difficulties and their answers are given in full in Appendix II (apart from identifying details relating to particular HDs or SDAs) and summarised on pages 50 to 53. Topics covered included the following:

(i) The organisation of the district or area concerned with running health centres, in particular problems relating to co-ordination and communication.

(ii) Administration within the health centre, including the pros and cons of having a locally based health centre administrator and the value of house committees.

(iii) The relationship between HD/SDAs and the general practitioner, in particular the financial arrangements, who should employ receptionist staff, and health centre administrators and integration.

INTRODUCTION

The first and second phases of the study

This is a report of a survey which formed the third and final phase of a study of the administration of health centres. Reports on the first two phases were issued in 1975 and 1978*. In these phases we were interested in finding out what administrative activities were needed in health centres and who undertook them, and in procedures for decision-making in and about health centres. In the first phase we looked at the situation before the N.H.S. Reorganisation of 1974 when health centres were the responsibility of local government health departments. In the second phase we looked at health centre administration after the 1974 Reorganisation, to see what were the effects of this change and to see if any other changes, not necessarily connected with Reorganisation, had taken place.

The work carried out in Phases One and Two demonstrated both the variety of arrangements possible for health centre administration and the general dearth of information about what arrangements were actually in existence in health districts and single district areas. We decided to try and fill this gap by conducting a postal survey on the subject, and this survey we refer to as 'Phase Three'.

Objectives of Phase Three

a) To find out what the preferred policy of single district areas and health districts in England was for the administration of their health centres.

b) To find out what the practice in single district areas and health districts was for administering health centres.

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* G. E. Baker and J. M. Bevan (1975) Management & Administration of Health Centres, HSRU Report No. 13.

G. E. Baker and J. M. Bevan (1978) The Management & Administration of Health Centres - A study of the affects of the 1974 Reorganisation of the N.H.S., HSRU Report No. 33.

Methods

The information for this survey was collected by means of a postal questionnaire addressed to district administrators or administrators of single district areas. In three cases, where visits were being made by us to a health district/single district area*, just before the survey was sent out, the same questionnaires were issued, and some completed at the visit, the remainder being returned to us later by post.

Two types of questionnaire were used in the survey. Questionnaire A was concerned with HD/SDA policy and views on health centre administration, and each district (or single district area) was sent one. Each Questionnaire B related to one health centre and had questions on both services in the centre and the administrative arrangements in use (see Appendix for copies of questionnaires and accompanying letters).

The questionnaires were piloted in May 1977, being sent to each of the six health districts in the Kent Area Health Authority. As a result of the pilot survey and some comments received on visits to HD/SDAs. slightly altered versions of the questionnaires were prepared and sent to remaining health districts and single district areas at the end of June 1977. The results of the pilot survey were however incorporated into those of the main survey.

Names and addresses of health districts and single district areas, and the names of their health centres, were obtained from the Health and Social Services Year Book 1977. A package of questionnaires was addressed to each district or area administrator as appropriate with a request that they forward these to appropriate persons for completion. Each package contained one 'A' questionnaire, as many 'B' questionnaires as there were listed health centres, two extra 'B' questionnaires (to cover any centres not listed), and a stamped addressed envelope for return to us. Districts with no centres listed were sent an 'A' questionnaire and two 'B' questionnaires.

A first reminder (a short letter) was sent out in August and a further letter was sent and telephone contacts made in the following weeks to HD/SDAs who had not responded, (see Appendix I for copies of letters). By January 1978 the final replies were received.

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* Henceforth usually abbreviated to HD/SDA.

Response

Out of the 205 health districts and single district areas approached in the survey 193 (94%) responded. Response from health districts was slightly better than that from single district areas (see Table 1). The response as distributed in the health regions was reasonably even throughout England. In seven regions out of the 14, all HD/SDAs responded; in two regions one HD/SDA did not respond, and, in the remaining five regions two HD/SDAs did not respond. (See Table 2).

We estimated the number of health centres 'missing' from the survey because of non-response. The number of missing centres was estimated by counting the health centres listed in the Health and Social Services Yearbook for 1978 (the year after the survey was sent out) for those HD/SDAs who had not replied. From this estimate it appears that 55 health centres out of a total of 765 were missing from the survey. Thus it is estimated that 7.2% of health centres were missing, compared to 5.8% of HD/SDAs. (See Tables 3 and 4).

The numbers of HD/SDAs and health centres upon which the results are based

Out of the 193 health districts and single district areas which responded to the survey, 23 did not have health centres, so that they did not answer Questionnaire 'A' on their policy and practice in health centre administration. The answers to Questionnaire 'A' then are based on the replies from the 170 HD/SDAs who had at least one health centre in operation.

From these 170 HD/SDAs we had details of 700 health centres. In addition, one HD gave details of its ten health centres but never returned Questionnaire 'A' on district policy and practice. For results concerned with health centres then, the results given are usually based on 710 health centres. Where results link the policy of HD/SDAs with information on the health centres, the results are based on 700 health centres.

RESULTS

Policy of the health districts and single district areas on the administration of health centres

Persons completing questions on policy

We asked for the name and position of the officer(s) completing Questionnaire A (on policy) and Questionnaire(s) B (on individual health centres). This first section on the results of the survey is about the policy of the HD/SDA on administering centres, and a relevant question is 'who provided these answers about HD/SDA policy?'. In fact a wide variety of administrative staff did so. (See Table 5). Over one fifth (23%) were completed by a sector administrator, the next most common respondents being a district (or area) administrator (16%), a community services administrator (14%) and a general administrator (11%).

Type of system in the HD/SDA for managing health centres

Information was given by the HD/SDAs on:-

a) the titles of the officers directly responsible for the administration of health centres in their district or area,

b) what responsibilities these officers had, if any, apart from administering health centres.

From this information we identified three basic systems for administering health centres, depending on the extent of responsibilities of the officer (or senior officer if more than one was mentioned) named as responsible for health centre administration. These systems do not necessarily coincide with the type of sector division in the HD/SDA.

These systems were:

1. Geographical - where the officer named was responsible for all (or almost all) of the services within a geographical area, including acute as well as community services. In some instances the responsibilities described excluded a particular type of service, such as geriatric, long stay or psychiatric.

2. Community - where the officer named was wholly or primarily responsible for community services. In some instances he was not responsible for all community services, or had some additional responsibilities such as for a small hospital.

3. Pragmatic - where health centre administration was added to the responsibility of a senior officer without any apparent rationale except convenience.

In 95% of HD/SDAs (162 out of 170), only one of the above systems existed. In the eight remaining HD/SDAs two different systems existed in different parts of the district or area. It should be noted that classifying an HD/SDA as having one system, means the same system of organisation is applied throughout the district or area. (See Table 6)

Among the HD/SDAs with one system in existence, 60% were of the 'community' type, 34% 'geographical' and 6% 'pragmatic'. In the eight HD/SDAs where two systems were in operation, half had at least one 'pragmatic' system but otherwise no particular pattern of combinations emerged.

Officers in the different types of systems

The total number of 'systems' in the survey amounts to 178. (This comprises the 162 HD/SDAs with one system, and the 16 systems in the eight HD/SDAs with two systems). In 134 out of these 178 systems (75%) only type of officer was named as responsible for administering health centres. In 41 (23%) two types of officer were named, and in 3 (2%) three types were named. The most commonly named type of officer (out of 225) was the sector administrator(51%) followed by the community services administrator (23%), unit administrator (5%) and senior administrative assistant (5%). These types of officer accounted for 84% of those named. The predominance of the sector administrator was marked in the 'two' and 'three person' systems - he was mentioned in four fifths of these, compared to a little over half of the 'one person' systems. (See Table 7).

Relation of system types to sectors in the HD/SDA

We did not ask in the survey about the type of sector organisation which existed in the HD/SDA (where this type of organisation was adopted), so we did not know if for instance the HD/SDAs had geographical or functional (e.g. community, acute, long stay) sectors. However where in the survey a

sector administrator was named in one of our system types as being primarily responsible for a geographical area, or for community services, we assume that the HD/SDA had a geographical or functional sector organisation respectively, and we applied this definition for the 162 HD/SDAs (out of 170 HD/SDAs) with one system only in operation. Using this definition, 91% of the HD/SDAs with 'geographical' systems in our survey also appeared to have a geographical sector organisation but only 53% of the HD/SDAs with 'community' systems appear to have functional sector organisations.

The only information about what sector types actually existed in these HD/SDAs. at that time was to be found in the Hospital and Health Services Year Book for 1978. In 19% of these, the sector type was not clear. However nearly one half had geographical sectors and a third had community sectors. In our survey the 'systems', divided on the basis of one third 'geographical' and over half 'community'. From this we inferred that about one half of our 'community' types of system were in fact sub divisions of a 'geographical' sector.

Arrangements for the day-to-day administration of health centres preferred by HD/SDAs

Those approached were asked to indicate which was the way preferred in their district/area for arranging the day-to-day internal administration of its health centres. From among a number of options listed in the question respondents could indicate more than one option, where they were considered equally appropriate, and in fact many did, see below. The full range of possibilities given in the questionnaire is shown in chart(p.54) and included the following kinds of arrangement:

i) a health authority employed administrator based in the centre with or without other administrative responsibilities;

ii) an administrator, such as a sector administrator, not based at the centre, to see to the day-to-day administration of the establishment with no person employed by the health authority being based at the centre itself for this purpose;

iii) the HD/SDA to leave the general practitioners of the health centre to arrange for someone employed by the practice(s) to carry out the day-to-day administration.

Many respondents indicated two or more such options but we begin by considering the number of respondents in total indicating a preference for each of the options listed (see Table 8).

In health districts (as distinct from single district areas), the most popular single arrangement was option (A), namely for the district to employ an administrator (or equivalent by another name) whose sole responsibility was for a single health centre and who is based in that health centre. The next most popular option was (F), that is 'district to arrange for an administrator such as a sector administrator or his assistant not based in the health centre to see to the day-to-day administration of one or more health centres, no person being employed by the district in the health centre for its administration.'

The other options each attracted considerably fewer votes and in particular, the least popular was (G), namely leaving the general practitioners in the health centre to arrange for someone employed by the practice(s) to carry out the day-to-day administration.

In the single district areas a somewhat different pattern emerged, as by far the most popular single option was (F) (see above), possibly a consequence of some single district areas being relatively compact urban areas, relatively easy to administer centrally. In single district areas also, the option that the general practitioner should be left to make arrangements to administer the centre, obtained relatively little support.

Since respondents often indicated several options as being equally acceptable, we now consider the preference of HD/SDAs as manifested by the total collection of options preferred by each. (See Table 9)

Forty-three per cent of health districts and 38% of single district areas only indicated one or more of options (A), (B), or (C) as preferred. That is to say they only indicated as a preferred arrangement, a health centre administrator based at a health centre, possibly with other responsibilities. Additionally a further 8% of health districts and 7% of single district areas confined their range of preferences to option (D), i.e. the district to arrange for a health authority employee such as a clinic clerk or a health visitor who is based in the health centre to undertake administrative tasks in that centre in addition to their other duties', with or without one or more options (A), (B), and (C). That is, this group also indicated preferences only for a health authority employee based in the centre to handle day-to-day administration of health centres. Therefore in all, about half of the respondents felt that a health centre based health authority employed administrator was the appropriate way to run their health centres.

Conversely 11% of the health district respondents and 21% of the single district area respondents indicated as the only preferred way of administering centres, option (F), 'the district to arrange for an administrator such as a sector administrator or his assistant not based in a health centre to see to the day-to-day administration of one or more health centres, no persons being employed by the district in the health centre for its administration'. A further 6% of health district respondents and 7% of single district area respondents indicated a preference only for option (E), that is a unit administrator not based in the health centre but for example in a local hospital who also undertakes the administration of the health centre, or of (E) with option (F),(see above), that is again a form of administration which does not involve having an administrator based in a centre.

Ten per cent of health districts and 14% of single district areas, indicated as at least one of their preferences option (G), namely leaving the general practitioners in the health centre to arrange for someone employed by the practices to carry out the day-to-day administration.

The remaining respondents mostly favoured a range of options which suggested that they found a centre based administrator and an administrator based elsewhere than in the health centre equally acceptable for the purpose under consideration.

Tables 10, 11, 12 show the actual arrangements found in health centres related to the preferences of the health district/single district areas, whose responsibility they were. Generally speaking the form of administration found in health centres was compatible with the set of preferred arrangements indicated by the HD/SDA, with the following exceptions.

1. In the case of a number of centres where the only favoured administrative arrangement specified by the HD/SDA responsible for that centre was option (F), that is to say 'sector administrator or his assistant not based in a health centre seeing to the day-to-day administration of the health centres,' this was not in fact the case, the centres being locally administered.

2. In the case of a number of centres where an employee of the general practitioners was at least one of those indicated as responsible for the day-to-day administration of the centre, the corresponding HD/SDA did not indicate such an arrangement (G) as one of those preferred.

Policy of HD/SDAs. employing at least one person based in a health centre to undertake its administration, on backgrounds, training, career structure and salaries for such persons

Limited response to questions on policy for health centre administrator type posts

The questions on background, training, career structure and salaries for persons appointed to health centre administrator type posts, were intended to be answered by HD/SDAs with these staff in post whether or not HD/SDAs preferred to employ such staff. Of the 170, HD/SDAs responding in the survey with at least one health centre functioning, 51 did not have health centre based staff for administering their health centres. This leaves 119 HD/SDAs to whom this section applies (on policy for health centre administrator type posts). However not all of these answered the section, and the response varied between 96 and 101 replies (out of 119) for the various questions.

Backgrounds considered suitable

Out of the 98 HD/SDAs answering this question, 24 mentioned having or studying for, HSA qualifications, as suitable for health centre administration posts. Clerical and secretarial backgrounds were mentioned much more often than administrative or supervisory experience. Health service experience of some kind, not necessarily in general practice or community health, was widely mentioned. Some HD/SDAs specified qualities, such as organising ability, and tact and charm for getting on well with people. (See Table 13).

Training for staff

Respondents were asked to give details of any training which it was the policy of the HD/SDA to give (a) to those staff newly appointed to health centre administrator post and (b) to those staff already in a health centre administrator post and 98 out of 119 HD/SDAs answered this question.

Of these 98 respondents (including one who said that the question about type (b) staff was not applicable) who did answer the questions 11 said that it was not the policy of their HD/SDA to give training to staff in situation (a) or situation (b), 12 gave some training to newly appointed staff (i.e. in situation (a)) but not to staff in post (i.e. those in situation (b)), while seven did not give training

to newly appointed staff but did give it to those in post. Sixty-seven gave training to staff of both categories.

Some respondents indicated that it was the policy of the HD/SDA to give more than one type of training to staff in situation (a) and/or in situation (b). Table 14 shows the frequency with which various kinds of training were mentioned in respect of staff in situation (a) and in situation (b). For new staff induction courses and visits to other health centres were easily the most common. For staff in post various management courses were mentioned as appropriate.

Tables 15 and 16 set out in further detail the combination of kinds of training mentioned by respondents for newly appointed staff and staff already in post as health centre administrators - separately accordingly to grades thought appropriate for health centre administrators by the HD/SDAs in question. (See page 11)

Predictably, respondents from HD/SDAs where no grade above HCO was mentioned as appropriate for health centre administrators, were less likely to mention any kind of management training than those specifying HCO as well as a higher grade such as GAA or SAA, who were in turn less likely to mention management training than those from HD/SDAs where the only grade(s) mentioned were GAA or above. The grade of staff thought appropriate for health centre administrators, did not appear to be related to whether training of some kind was given.

Career structure

Of the 96 HD/SDAs who answered this question,

40 thought that a career in health services administration generally was possible for health centre administrators, and a further 29 saw a career in community health services administration as appropriate. Thus a clear majority of those answering recognised career opportunities above the level of health centres. Only eleven HD/SDAs felt that there was no career beyond the health centre for staff in these posts. HD/SDAs with a 'community' type system were rather more likely to see career opportunities beyond the health centre, than were HD/SDAs with 'geographical' systems. (See Table 17). The number of health centres in the HD/SDA did not have any apparent effect on the career possibilities thought appropriate, except that that those with only one or two centres were more likely to see career opportunities beyond the health centre than those with more centres. (See Table 18)

Appropriate salary grades

HD/SDAs were asked to indicate grades thought appropriate for health centre administrator posts, and of the 100 who answered this question, 47 mentioned one grade, 53 mentioned two. The grade most frequently mentioned was General Administrative Assistant (77), followed by Higher Clerical Officer (58). Senior Administrative Assistant (11) and Clerical Officer (4) were far behind in frequency. (See Table 19). Generally, for staff based in health centres, their actual salary grades coincided with one of those preferred by the HD/SDAs (See page 24).

Criteria for deciding between grades for health centre administrator type posts

Out of the 55 HD/SDAs who gave their criteria, the majority (42) mentioned the size of the centre and general extent of services provided there. The number of general practitioners in the centre was another factor mentioned (24), as was the extent of work done by the administrator in clinics and other community services (20).

Preference of HD/SDAs on whether general practitioners should contribute to payment of health centre administrators

Half (51) of the 101 HD/SDAs who answered this question preferred to pay the whole salary of those employed in a health centre for its administration. Nearly as many (45) preferred the general practitioners to make some contribution. Health districts were more evenly divided than the single district areas on this - the latter mostly preferred to pay all of the salary. (See Table 20). With some exceptions (see page 28) HD/SDAs generally contributed to the payment of salaries for health centre administrator type posts in the way which they said they preferred.

Preference of HD/SDAs on who should employ health centre reception staff

HD/SDAs were evenly divided on this question, 71 preferring to employ staff themselves, 70 preferring the general practitioners to employ staff, the rest (29) not having a preference. Health districts were more likely to prefer to employ reception staff themselves than were single district areas. (See Table 21). In practice, HD /SDAs did not always employ reception staff in centres as they would have preferred. In health centres administered by HD/SDAs who preferred to employ reception staff themselves, two thirds in fact did this. In health centres administered by HD/SDAs who preferred the general practitioners to employ reception staff, 87% of the general practitioners employed their own staff. (See Table 22).

Preferred arrangements for liaison between person(s) based in the health centre responsible for day-to-day administration, and other officers in the district

Of the 158 HD/SDAs who opted for one liaison arrangement, 56% preferred that persons in the health centre should contact both functional and administrative officers, as appropriate, and 37% that liaison should be with an administrative officer only. Only 3% opted for contact with functional officers only. Out of the 12 HD/SDAs who opted for two types of liaison arrangment, 11 in effect selected combinations of liaison with functional and administrative officers.

Attitudes towards health centre house committees

Importance of committees

A clear majority (80%) of HD/SDAs considered that having a house committee in health centres was essential or desirable. Only three HD/SDAs regarded such committees as undesirable. Relatively more single district areas than health districts regarded committees as essential, and no SDAs felt that they were undesirable. HD/SDAs who favoured having health centre house committees were more likely to have them - and vice versa. (See Tables 23 and 24).

Membership of committees

HD/SDAs were asked how important various persons were for membership of the health centre house committees. HD/SDAs clearly preferred to have general practitioner representatives of each practice in a health centre, rather than all the general practitioners on the committee. A substantial majority (78%) also thought a health centre administrator (if in post) was an essential member of the committee, and there was more support for having a nurse based in the centre (59%) as a member than a nursing officer not necessarily based in the health centre (32%). Feelings about having an F.P.C. or a receptionist representative were fairly evenly divided. A consumer representative was not popular, nearly half the answering HD/SDAs being against the idea. An administrative officer from the district or sector was generally thought desirable as a committee member. Of the 114 HD/SDAs who specified which officer they thought most appropriate, 45% selected a sector administrator, and 23% a community services administrator. (See Tables 25 and 26).

Other persons mentioned as appropriate for a health centre house committee

The most frequently mentioned additional person was a dental officer (44 mentions) followed by a District Community Physician or Area Medical Officer (26) and chiropodist (22). Community Medical Officers were mentioned by 16 HD/SDAs but a Consultant only by one. Social workers were mentioned by 10. Altogether there were 200 entries for 'other persons'. (See Table 27).

Existence of health care planning team for community or primary health care services

In 27% of the health districts and 48% of the single district areas there were health care planning teams for community or primary care services. Most of the remainder reported that they did not have such a team although a few indicated that these services were considered within functional health care planning teams, e.g. child health, the elderly. Health care planning teams for community or primary care services were more likely to exist in HD/SDAs which had a 'community' type system for administering their health centres. (See Table 28).

Information about individual health centres

Persons completing questions on individual health centres

One Questionnaire'B'was completed for each health centre. These questionnaires were completed by a much wider variety of staff than were the 'A' questionnaires (on HD/SDA policy). Sector administrators completed nearly a quarter (24%) of the 'B' questionnaires, and together with community services administrators or their deputies (15%) and health centre administrators (9%) accounted for 58% of those completing'B' questionnaires. The remainder were completed by a variety of staff. (See Table 29).

Year of opening of health centres

Table 30 shows the health centres in the survey by their year of opening, from 1948 to mid 1977. Few centres (46) came from the period 1948-1966 but in 1967 there is a marked increase, rising to a peak in the early 1970s. (88 in 1974 alone) and tailing off thereafter. This pattern of openings reflects the national trend in health centre building shown in the annual figures for openings given in D.H.S.S. Annual Reports. In some cases, particularly for older health centres, the date of opening given in the questionnaire may be approximate, as the centres were built before the present HD/SDAs had come into existence.

Total number of general practitioners in the health centres

Eighty three per cent of the centres were used by eight or fewer general practitioners (including those working mainly elsewhere). Indeed 44% of them were used by less than five family doctors. The average number of general practitioners using a centre (including those working mainly elsewhere) was 5.6 while the average number using a centre as their main surgeries was 5.0. In fact 11% of general practitioners using health centres worked mainly elsewhere. In 24 health centres all the general practitioners holding surgeries there were based mainly elsewhere. In addition there were five health centres where no general practitioners worked at all. (See Tables 31 and 32).

The number of practices working from health centres

In 49% of the centres, all the doctors working there (including those based mainly elsewhere) were members of a single practice. There were two practices in 22% of the health centres, three practices in 15% of the centres and four or more in 13% of the centres. Predictably among the small centres used by four or fewer general practitioners, the great majority involved only a single practice although about one in six of these small centres was used by more than one practice. There were three or more practices in 37% of the centres used by five to eight doctors, in 67% of those used by nine to twelve general practitioners, and in almost all of the larger centres. (See Table 31).

Adjacent premises

Out of the 710 health centres, 11% had some type of hospital adjacent, over half of which were general practitioner hospitals. Seven per cent were adjacent to clinic premises, 4% were adjacent to some other type of N.H.S. owned premises, including e.g. offices and ambulance stations. (See Table 33). Therefore, most health centres were not adjacent to health service premises.

Consultant sessions in health centres and adjacent premises

Almost a quarter of health centres or adjacent premises provided at least one type of consultant session. The most common specialty was psychiatry (10% of health centres) followed by paediatrics (5%), E.N.T. (4%), orthopaedic (4%) and gynaecology (3%). (See Table 34).

Other services provided in health centres

Apart from the usual services provided by the primary health care team and consultants, health centres may provide a variety of other health and related services. The most commonly mentioned of these services was chiropody(in 81% of health centres) followed by speech therapy (64%) and school dental services (57%). Over 29% of centres had social work sessions, 21% child guidance, and 16% physiotherapy. More rarely found services included general dental (8%), general pharmacy (4%) and X-ray (3%). (See Table 35).

House committees in health centres

Nearly half (48%) of health centres had house committees. Centres were much more likely to have committees if they had opened since 1973. Also the greater the number of general practitioners or practices in the health centre, the more likely it was that there would be a house committee. (See Tables 36 and 37).

Employer of reception staff (see also relevant section on policy)

Reception staff were employed by general practitioners in over 60% of health centres. In the remainder the health authority employed them, and in a few employment arrangements varied between practices. HD/SDAs were more likely to be the employers of reception staff in centres with several doctors or several practices. (See Tables 38 and 39).

Characteristics of those responsible for the day-to-day administration of health centres*

Titles of those named as responsible for the day-to-day administration of health centres.

Respondents from the health districts and single district areas were asked in the case of each health centre in the HD/SDA to list the titles of person(s) responsible for the day-to-day administration of health centres. Space for up to three persons was allowed in the questionnaire. In the case of 538 centres, one person only was listed;in 133 centres, two persons were listed and in 33 centres, three persons were listed. In the rest of this report these centres will be referred to respectively as 'one person', 'two person' and 'three person' centres. Six centres had no person mentioned as responsible for day-to-day administration and so these are excluded from this discussion.

Table 40 shows the distribution of all persons responsible for the day-to-day administration of centres by title, for one person, two person and three person centres.

One person centres were equally prevalent in 'geographical' and 'community' type systems and more prevalent in'pragmatic'systems (See Table 41).

The one person centres

In the case of one person centres but not of the others, health centre administrators account for a substantial proportion (39%) of the persons mentioned. Other 'local' employed administrators (clerks, clinic clerks, secretaries/receptionists) were responsible for the day-to-day administration of a further 27% of centres. Practice administrators were responsible for the administration of 3%. Nurses and nursing officers were also responsible for 3% of the centres.

The centrally based administrators (sector administrators, community service administrators and most of the class labelled miscellaneous administrators) accounted for a further 20% of the centres.

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* It should be noted that in a number of cases, the same administrator is responsible for more than one health centre. Such an administrator would be accounted in the analyses as many times as the number of centres with which he is concerned.

(The group we have been labelling miscellaneous administrators (see Tables 51, 52 and 53) were mostly relatively senior centrally based staff in the case of one and two person centres, though in the case of three person centres, the label clearly covered a wider range of staff).

The two person centres

Only very exceptionally would two persons of the same title be responsible for the same health centre so that effectively for any title, the proportion of the staff with that title per health centre is double that quoted in Table 40 in respect of the total number of persons listed (i e. working on a base of 133 health centres instead of 266 persons).

This said it can be seen that a common pattern is for a central administrator (a sector administrator or a community services administrator) to be paired with a local administrator such as a clinic clerk or secretary/receptionist or a functional officer such as a nurse/health visitor or domestic supervisor. (We use the word functional here to cover a very wide range of staff, to distinguish them from someone whose primary purpose is general administration). Occasionally, a pair of central administrators are listed as having responsibility for a centre and more commonly a pair of local administrators, such as a clinic clerk working with a secretary/receptionist. The health centre administrator is a relatively uncommon figure, being involved in the administration of only 12% of these health centres - arguably because less responsibility is devolved to administrators at the local centre. (See Table 42).

The three person centres

There were relatively few of these so it is difficult to discern any dominant patterns. The most common arrangement was for one or two central administrators to be teamed with a local and/or functional administrator. The other relatively common arrangement was for one or two local administrators to be teamed with two or one functional administrators. Generally in this group, nurses appeared much more commonly as one of those involved in the day-to-day administration of health centres. (That is a nurse was mentioned as having such responsibility in 3% of the 'one person' centres, in 13% of'two person' centres and in 36% of the 'three person' centres). The health centre administrator is again an uncommon figure featuring in only 6% of the 'three person' centres. (See Table 43).

Employment arrangements of those responsible for the day-to-day administration of health centres

The persons listed as responsible for the day-to-day administration of health centres were also classified (by those responding) according to their 'employment arrangements', that is to say, where they were based, their responsibilities, and who employed them.

The categories used were as listed in Chart on p. 54 Broadly speaking categories A to C inclusive were local health centre administrators running one or more health centres and based in one of these though possibly administering other facilities such as clinics or hospitals of some description. Category D again covers a local health centre based health authority employee, such as a clinic clerk or nurse.

Category E was a unit administrator based elsewhere than in a centre, category F was a health authority employee such as a sector administrator or other centrally based person rather than a unit administrator, based away from the centre. Categories G and H were general practitioner employed staff who administered the health centre as all or part of their duties.

One person centres

The most common single arrangement was A (covering 35% of the centres), that is a health authority employed administrator based in the centre with responsibility for the administration of that centre only. The categories B and C where the administration of health centres was combined with other duties, involving other health centres, clinics or hospitals were relatively common accounting for a further 21% of the persons mentioned. Thus what were essentially health centre administrators based in health centres with primary responsibility for one or more health centres accounted for over half of those responsible for the day-to-day administration of one person centres. (See Table 44).

A health authority employee, such as a clinic clerk who handled the day-to-day administration of health centres in addition to other duties and based in the health centre, accounted for 14% of the centres.

Thus in all , 70% of the health centres were administered on a day-to-day basis by a local health centre based person employed by the health authority. A further 6% were administered by G.P. employed staff.

The remainder of the centres were administered by either a unit administrator based elsewhere (6%) or by another health authority employed administrator based elsewhere (usually centrally).

Some further insight into the nature of the administrators is obtained by looking at Table 45 which tabulates employment category and title.

In particular the categories A, B and C taken together were largely (63%) taken up by those designated as health centre administrators, the remainder being mainly secretaries/receptionists or clinic clerks/clerks with the occasional unit administrator, nurse, community service administrator, cleaner caretaker and even one sector administrator.

Category D, health authority employed staff again accounted for most of the clerks or clinic clerks, together with some secretary/ receptionists and the majority of the nurses with administrative responsibilities for health centres. Category F was almost entirely composed of those we have described elsewhere as central administrators (sector administrators, community service administrators, and miscellaneous administrators) and a number of those we classified by title as miscellaneous administrators were to be found in category E (unit administrators) and there were even a few cases described as health centre administrators, category A, B or C.

Two person centres

In these centres a health centre administrator of some kind (i.e. of type A, B or C) was found in 47% of the centres (see Table 46). In 30% of the centres there was no A, B, or C type administrator but there was a local administrator of type D in post. Thus there was some form of local health authority employed administrator either based in the centre or another centre in 77% of the two person centres. In addition a further 5% of two person centres have a G.P. employee in an administrative post. In the case of about half of the centres with a local administrator, this person was joined by either a unit administrator (type E) or a central administrator (type F). In the remainder of these centres, there were two local administrators either both health authority employed or, particularly where one was a type D administrator, the other was a G.P. employed administrator. The remaining 20% of the two person centres, i.e. those without a local administrator in post, were mostly administered by either two central administrators (type F) or a central administrator and a unit administrator (type E).

There is a superficial similiarity between the one person and two person centres in the proportion of centres having a local health centre based administrator responsible for the day-to-day administration. However there were very few staff designated as health centre administrators among the local administrators for the two person centres, these persons tended more often to be labelled as secretary/receptionist or clinic clerk, i.e. job descriptions tended to have a lower status. It also emerges that a number of the local centre based administrators were functional officers such as nurses, domestic supervisors or cleaner/caretakers. (See Table 47).

Three person centres

Twenty-eight out of 33 such centres had at least one locally based health authority employed administrator responsible for health centre administration (i.e. administrator type A, B, C or D.) In the remaining five, there was at least one practice employed local administrator listed. Thirteen of these local administrators were supported by at least one central (F type) administrator and in addition a further two by a unit administrator (E type). As to the rest, in ten all the administrators were local i.e. all are of types A, B, C, D, G and H. (See Table 48).

The cross tabulation of the three person administrators by employment category and title leads to similar conclusions to those noted for two person centres. That is, the local administrators based at health centres tended to be secretary/receptionists or clinic clerks, with some nurses. (See Table 49).

Comment

What can we then conclude about the administrative arrangements for health centres? In the great majority of centres it was the case that there was at least one locally based administrator responsible for the day-to-day administration of that centre. These were probably of a higher status in the one person centres than in the two person and three person centres. Functional administrators, whether nurses or cleaner/caretakers, often described as being based at the health centre, were found more frequently in two and three person centres than in one person centres.

. Salary grades of those responsible for the day-to-day administration of health centres

a) Salary grades for the various job titles

One person centres

The two grades HCO and GAA were the most commonly used (Table 50) accounting between them for 60% of the persons named. In particular the GAA grade covered 31% of those named. Nine per cent of those responsible for the day-to-day responsibility of health centres were graded CO and 19% were in the more senior grades of SAA or PAA. The remainder were spread relatively sparsely over a variety of grades or arrangements such as G.P. employed (i.e. not on service grade) or on a nursing grade.

In particular among those entitled health centre administrator, 50% were on the GAA grade, 35% on the HCO grade and 9% on the SAA grade, the remaining 6% on sundry grades. By contrast the secretary/receptionists were usually graded HCO (61%) with some on the clerical officer grade (17%). Clinic clerks/clerks were evenly divided between the HCO and CO grades.

Two person centres

In these centres because of the wider range of personnel involved in the day-to-day administration, the staff mentioned by title were spread much more evenly over various grades. Thus GAA and HCO grades between them accounted for only 25% of the staff while the SAA and PAA covered 29% and there were 12% on the CO grade. Both G.P. employed staff and nurses were more common in two person health centres than in one person centres. Among the local 'administrators', the GAA grade was only used for health centre administrators, then only for slightly more than a third of the relatively few persons so described - the HCO grade was slightly more popular for these. The most common grade for secretary/ receptionist was HCO and that for clinic clerk/clerk was CO. (See Table 51).

Three person centres

Among staff from these centres, the CO grade was easily the most common one indicated (27%), otherwise the staff were fairly evenly divided between the various grades with 15% belonging to the SAA and PAA grades and 11% to the combined grades of HCO or GAA. In these centres easily the most common grade for secretary/receptionist or clinic clerk/clerk was CO. (See Table 52).

Comment

Generally then in the two and more especially the three person centres, the local non-nursing administrators were placed on lower grades than those in one person centres - partly no doubt because they were frequently supported by central staff or functional staff of some seniority such as nursing staff. This suggests in particular that there is a real difference in practice between the one person centres and the two and three person centres. So it is not just a question of the omission of more senior or functional staff from the list of those responsible for the day-to-day administration in the case of one person centres (despite the fact that they were to some degree involved in such administration) but rather that in these centres there was more delegation of responsibility to the local administrators.

b) Salary grades for various employment categories

One person centres

The primary interest here is in the salary grades in relation to the responsibility of the local administratores, (i.e. those of type A, B, C and D, see Chart on p.54)

Type A administrators, that is to say those with responsibilities for one centre only were most often HCO or CO (56% were in these categories) but about one third were graded GAA and 6% SAA. Predictably the B and C type administrators with responsibilities for more than one centre or other facilities in addition to this centre were more usually graded GAA or higher (see Table 53), though even here a number were on the HCO grade. Type D administrators, usually dealing with the administration of their centre in addition to other primary duties were usually either graded HCO or CO, or on one of the functional grades (since nurses with responsibilities for health centre administration tended to be classified under D).

Predictably unit and central administrators (types E and F respectively) were almost invariably graded GAA or above, usually above in the case of F type administrators.

Two person centres

The main difference between the gradings for the staff of these centres and those from one person centres lay in the classification of the A type administrators, that is those with responsibilities for one centre only. In the two person centres, these administrators were either almost all graded HCO or CO, or were on a 'caretaker' grade. As in the one person centres, type D administrators were graded CO or HCO except for the larger proportion of nursing staff to be found in this category in the two person centres. See Table 54).

Three person centres

Once again in comparison with one person centres, type A administrators were either on a relatively low administrative grade,(CO)or a functional grade such as a caretaker. Type D administrators were seldom graded above CO except in the case of nurses. (See Table 55).

Comment

Thus the primary difference emerging between one person centres, and two or three person centres was that the local administrator in the two person and three person centres was usually on a relatively low grade. This probably reflected the fact that they were often supported by a higher graded officer at unit or central level or by some one such as a nurse.

c) Salary grades of selected staff responsible for the day to day administration of health centres, in relation to the salary scales preferred for such administrators by respondents representing HD/SDAs

The staff considered in this section are those with the following titles only:-

Health centre administrator

Other staff :-

Senior secretary or senior receptionist

Secretary or receptionist

Clerk or clinic clerk

since these essentially constitute the group of administrators based at centres rather than elsewhere in the HD/SDA and usually also employed by the HD/SDAs. The answers of the HD/SDA are general responses about salary

grades for staff responsible for the day to day administration of health centres and do not relate to administrators of any particular health centre or to any particular individual. The answer of an HD/SDA respondent will be counted as often as the number of health centres in the HD/SDA in the category under consideration.

Health centre administrators

One person centres

There were in all 199 staff with the title of health centre administrator in one person centres, where the views of the HD/SDA were known. Of these, 51% were on the GAA grade, 34% were on HCO grades, 9% on SAA grades, 4% on local authority grades which had not been changed probably since reorganisation at the time of the survey and the remainder on miscellaneous grades. Thirty-eight per cent of HD/SDAs thought GAA or SAA (and nothing lower) appropriate, 14% thought HCO or CO (and nothing higher) appropriate, 9% did not answer (a very low proportion when compared with that for other job titles considered), the remainder selected more than one salary grade as appropriate which almost invariably included HCO and a higher grade such as GAA or SAA. (See Table 56).

The largest group of health centre administrators (101) were those on the GAA grade. For 93 of these, the HD/SDA respondent included the GAA grade as one of those thought appropriate : for 48 it was the only one listed as appropriate), and most of the rest thought HCO another appropriate grade - the remaining 8 mentioning SAA as an alternative grade to GAA.

Of the 68 health centre administrators graded as HCO, the HD/SDA respondent mentioned HCO as one appropriate grade in 53 cases (most of the rest did not give an answer about this). For 16, HCO was the only grade mentioned as appropriate and for 28, HCO and GAA were both mentioned as appropriate grades. Taking these with a further five who mentioned GAA or SAA as one appropriate grade, this means that in the case of 33 of these staff, one of the grades mentioned by corresponding HD/SDA respondents was that of GAA or higher.

In the case of 17 health centre administrators graded as SAA, the corresponding HD/SDA respondents indicated SAA as an appropriate grade in the case of 12 - the remainder listed only

grades below this, i.e. HCO and/or GAA.

Broadly speaking, health centre administrators appeared to be on the salary grades thought appropriate by the relevant HD/SDAs.

Two and three person centres

There were only 18 of these altogether in two and three person centres considered together and these were almost equally divided between HCO (7) and GAA (7). Of those graded as GAA, the corresponding HD/SDA stated that the only grade thought appropriate was GAA, in the case of six,no answer being given in the case of the seventh. In the case of the seven graded as HCO, one of the corresponding HD/SDA respondents thought that CO and HCO were appropriate grades, four that HCO only was an appropriate grade and two that HCO and GAA were appropriate grades. Overall then the opinions of HD/SDA respondents associated with five out of the 14 centres where answers were available thought that a grade of HCO or less was appropriate and six thought the grade of GAA was appropriate and the remaining three thought HCO and GAA to be acceptable. (See Table 56).

Other staff

In this section information about senior secretaries/senior receptionists,* secretaries/receptionists and clerks/clinic clerks is considered.

One person centres

Eighty per cent of the senior secretaries/senior receptionists were graded as HCO, the remainder being divided evenly over an assortment of grades (see Table 57). Of those with the title secretary/receptionist, just over half were on the CO grade with a quarter on the HCO or a higher grade. Clinic clerks were mostly equally divided between those graded as CO and those graded as HCO. (See Tables 58 and 59).

Generally speaking the grades on which the staff were placed were compatible with those suggested as appropriate by respondents from the corresponding HD/SDA. The one exception to this statement occurred in the case of those secretaries/receptionists and clinic

*This is the only occasion where senior secretaries/senior receptionists are considered separately from secretary/receptionists - otherwise the term secretary/receptionist includes senior secretaries and senior receptionists.

clerks/clerks who were graded as CO. The majority of respondents in corresponding HD/SDAs. who answered the question at all gave as appropriate grades for those undertaking the day to day administration of health centres, only higher grades, such as HCO and/or GAA. It has to be borne in mind that the HD/SDA respondents were expressing an opinion about suitable grades for those with administrative responsibilities for health centres generally, and not in relation to particular centres. Moreover in the questionnaire, they were only intended to answer this question where the HD/SDA had staff of type A, B or C, (see Chart on p.54) in post, whereas clinic clerks, clerks and secretaries/receptionists were often classified as being of type D. However we are discussing the only person having day to day responsibilities for health centre administration at the centre in question so we cannot rule out the possibility that some at least of the staff graded as CO were undertaking duties for which the appropriate grade was considered to be HCO or above by the corresponding HD/SDA respondent. The fact that many HD/SDA respondents did not answer the question at all,(particularly in the case of HD/SDAs corresponding to centres with clinic clerks/clerks and secretaries/receptionists, listed as being responsible for health centre administration,) is usually because the district or areas in question have no health centre administrators of types A, B or C in post at all and so did not answer the relevant questions in Questionnaire A

Two and three person centres

Generally the staff with the titles under consideration were on the lower grades than those in one person centres but otherwise the remarks made in relation to those working in one person centres, applies to these staff also. (See Tables 57, 58, and 59).

The division of the cost of salaries of those responsible for the day-to-day administration of health centres between the health authority and general practitioners.

Those responsible for the administration of health centres on a day-to-day basis could have their salaries paid entirely by the health authority, or entirely by the general practitioners, or the cost of their salaries could be shared between the health authority and the general practitioners. (Of course a proportion of the general practitioners' share will also be reimbursed to them in the normal way for ancillary staff).

a) The division of the costs of salaries in relation to title

Predictably, with very rare exceptions, staff with the following titles were almost invariably paid entirely by the health authority - sector administrators, community service administrators, hospital and unit administrators, domestic supervisors, nurses, health visitors and nursing officers, and miscellaneous administrators.

Interest therefore focusses in this section on staff having the following titles - health centre administrator, secretary/receptionist, clinic clerk/clerk, practice administrator and cleaner/caretaker.

One person centres

Taking the staff as a whole (i.e. not just the categories mentioned above) 62% were paid for entirely by the health authority, 5% entirely by the general practitioners, and in the case of almost all the rest, the cost was shared. One hundred and seventy-two of the administrators identified fell into the 'shared' category and in the case of 151 of these, the percentage paid by the health authority was known. Among these 151 staff, in the case of 30% the health authority's share was 70% or more of their salary cost and for a further 36% the share was in the range of 50-69%; for 17% the share was 30-49% and for 16% the health authority's share was less than 30% (see Table 60)

Among health centre administrators, 4% were paid entirely by the general practitioners, 48% entirely by the health authority and the cost of the remainder was shared by the general practitioners and health authority. Among the 89 health centre administrators for whom the percentage share of the health authority towards the cost of their salaries was known, in the case of 36% this was 70% or more, in the case of 45% the share was in the range of 50-69% of the salary cost and in the remaining 19%, it was less than 50%.

Perhaps not surprisingly among practice administrators (and there were relatively few of these identified), about half were paid for entirely by the general practitioners and generally where the health authority made a contribution, it was more likely to be less than half the salary cost.

Among secretary/receptionists, 36% were paid for entirely by the health authority and 16% were paid for entirely by the general practitioners. The cost was shared by the health authority and general practitioners for the rest though in rather more than half the cases for which the share was known (61%), general practitioners bore the larger part of the cost.

Among clinic clerks, 76% were paid entirely by the health authority and for almost all the rest, the cost was shared by the health authority and general practitioners. Where the cost was shared between the health authority and the general practitioners, in about half of these cases the health authority paid more than 50%, and in the remainder the health authority paid less than 50%.

The cost of the cleaner/caretakers was shared in all six cases identified in this survey and the health authority always paid at least 50% of the salary.

Two person centres

Among the 266 staff (covering the 133 centres in question), the cost of salaries was born entirely by the health authority for 76% of the staff and entirely by the general practitioners for 7% of the staff. The cost of the rest was shared between the health authority and the general practitioners. The percentage share of the health authority was known in the case of 25 (out of 37) of this last group of staff. This share was 70% or more of the salary cost for 20% of those involved; in the range 50% to 69% for 16% of the staff; in the range 30% to 49% for 20% of the staff; and less than 30% for the remaining 44% of the staff (see Table 61).

Among those styled as health centre administrators (and only 16 fell into this category), one was paid for entirely by the general practitioners, eleven entirely by the health authority and the cost was shared by the health authority and general practitioners in the case of four. Practice administrators were usually paid for entirely by the general practitioners.

Among secretary/receptionists, 19% were paid for entirely by the health authority and 16% were paid for entirely by the general practitioners. The cost was shared by the health authority and general practitioners for almost all the rest and the share of the health authority was known for 13 of the 19 staff involved. It was usually less than 30% of the cost.

Among clinic clerks and clerks, 74% were entirely paid for by the health authority, 5% entirely by the general practitioners and the cost was shared in the case of the remainder. Among the seven staff in this category for whom the authority share was known, this was usually less than 50% of the cost.

The cost of 13 of the 16 cleaner/caretakers was borne entirely by the health authority, and in two cases was shared by the health authority and the general practitioners.

Three person centres

Among the 99 staff (covering 33 centres in question) 76% were entirely paid for by the health authority and 9% entirely by the general practitioners. The cost of the remainder was shared between the health authority and the general practitioners and the health authority's share was known in 14 of these 16 cases - in six of these it was less than 50% and in the remainder 50% or more (see Table 62).

Among these 99 staff, only two were designated as health centre administrators and the salary costs of both these were shared between the health authority and the general practitioners.

Of the five practice administrators in this group, all were paid for entirely by the general practitioners.

Among the sixteen secretary/receptionists, six were paid for entirely by the health authority, three entirely by the general practitioners and the costs of the remainder were shared between health authority and general practitioners. The percentage paid by the health authority was known in the case of six of the seven staff in question. In all but one, this percentage was 70% or more.

Among the fifteen clinic clerks or clerks, the health authority paid all of the salary for all but one of these for whom their share was in the range of 30% to 40%.

The health authority also paid all the salary costs of six of the eight cleaners and/or caretakers contributing 30% or less as their share in the case of the remaining two.

Comment

In the case of the one person centres, the health authority was somewhat less likely to pay all of the salary of the administrators involved than was the case in the two and three person centres. Of course it must be borne in mind that when we speak of certain staff being involved in the administration of centres, it does not mean that this was their only duty. In many cases, particularly in the two and three person centres, some of the officers would only spend a small part of their time on health centre administration. The percentage of staff for which the general practitioners paid all the salary was relatively small in all types of centre. However if one considers the number of centres in which one person at least was paid for entirely by the general practitioners, this number was somewhat greater in the case of the two and more particularly three person centres. This is probably because of the tendency of a local administrator to work in conjunction with a central administrator, the latter being almost always health authority financed. Among the staff whose salary costs were shared by the health authority and general practitioners, the health authority was likely to pay a somewhat larger proportion of the costs in the case of the one person centres than in the two person centres and more particularly the three person centres.

b) The division of the cost of salaries classified by employment category

Generally speaking for all types of centre (that is to say one person, two person and three person centres) the following observations hold true (See Tables 63, 64 and 65).

Among those classified as essentially health centre administrators (employment categories A, B and C) those with the responsibility for more than just a single health centre (for example, with in addition responsibility for another centre or hospital) were more likely to be paid entirely by the health authority than type A administrators (looking after and based at just one centre). This was particularly the case for two and three person centres. Among A type administrators, generally about half were paid for partly by the general practitioners.

Predictably the D type staff,(for example clinic clerks or health visitors administering health centres in addition to their other duties) were mostly paid for entirely by the health authority but for around 20% some contribution was made by the general practitioners.

More senior health authority administrators (type E and F) were almost invariably paid for entirely by the health authority.

G.P. employed staff were usually paid for entirely by the general practitioners but in the case of around 20%, the health authority made some contribution.

c) The division of the cost of salaries classified by salary grade.

One person centres

Eighty-seven per cent of the administrators of one person centres were on one of the five main health authority administrative or clerical grades, namely principal administrative assistant, senior administrative assistant, general administrative assistant, higher clerical officer and clerical officer. The most senior officers, the principal administrative assistants, were always entirely paid for by the health authority and the great majority of the next highest grade, senior administrative assistant, and the lowest grade, clerical officer were too. The two grades where general practitioners paid at least some of their salaries were the higher clerical officer, where this was the case for 87%, and general administrative assistants where the authority made some contribution at least for 31% of those involved. (See Table 66).

Generally where the cost of salaries was shared, the health authority bore the greater proportion of the cost of general administrative assistants than of higher clerical officers.

The remaining 13% of administrators were on a variety of salary grades. Of the 16 who were paid on a nursing grade, 14 were entirely paid for by the health authority and in the case of the remaining two, general practitioners paid at least some part of their salary. Among 'G.P. employees', twelve were paid for entirely by the general practitioners themselves and the health authority made a contribution to the cost of the remaining two. All six of those in caretaking grades had their salary grades shared between the general practitioners and the health authority with the latter invariably contributing the greater part of the cost.

Two person centres

The health authority paid entirely the cost of salary of all or almost all of the following grades of officer, principal administrative assistant, senior administrative assistant and general administrative assistant. Fifty-seven per cent of the higher clerical officers' salaries were paid for entirely or in part by the general practitioners and the general practitioners also made some contribution to the salaries of a minority of the clerical officers.

As in the case of one person centres, almost all the nursing grades were paid for entirely by the health authority. Among those in the caretaking grades, most were, as in one person centres, paid for entirely by the health authority. In the two person centres, there appears a class of officer not mentioned in one person centres at all, namely those in the domestic staff grades. These were all paid for entirely by the health authority. (See Table 67).

Three person centres

The situation was very much as in the case of two person centres (see Table. 68).

d) Preferences of the HD/SDA as to whether or not they should pay the whole or some of the salaries of those administering health centres, in relation to what actually happened in the case of selected administrators

Health Centre Administrators

In one person centres where HD/SDAs preferred to pay all the salary of such staff, in fact for about 84% of the staff in question this was the case. Conversely in HD/SDAs where it was preferred that the general practitioners should pay some part of the salary, this was the case for 83% of the administrators in question. (There was a dispute about the percentage to be paid in the case of one centre administrator in a district where it was preferred that the general practitioner should pay some part of his or her salary). A very similar result was found for the relatively few health centre administrators in two person centres and there were only two health centre administrators in three person centres. (See Table 69).

Clerks/Clinic Clerks

Generally speaking HD/SDAs in the case of one person centres paid all the salary of three-quarters of these staff and in fact in the case of clerks and clinic clerks in HD/SDAs where it was preferred to pay all, 26 out of 27 had their salary totally paid by the HD/SDA. Also where HD/SDAs did not mind whether or not the general practitioners contributed to the cost of the salary, in all cases the clerk/clinic clerk was wholly paid for by the HD/SDA. By contrast where the HD/SDA preferred that the general practitioners should pay some part of the cost, the majority of these staff were still wholly paid for by the HD/SDA. These remarks apply also for two and three person centres staff. (It should be noted that there were a lot of 'not applicable' and 'no answers' for clerks and clinic clerks about HD/SDA preferences - about a quarter were not applicable and a fifth gave no answer). (See Table 70).

Secretaries and Receptionists

For the majority of these staff in one person centres, general practitioners either paid all (about 15% of the staff involved) or some part - a further 50% of those involved. For a third of the staff in this category, the HD/SDA preferred to pay the whole of the salary and did in fact do so in the case of two-thirds of these. Likewise where the HD/SDA preferred general practitioners to pay some part, in most cases (79%) this did in fact happen. The above remarks which applied to one person centres also applied to the relatively few staff in two and three person centres. (Once again a high proportion of staff were in health centres where the answers to the question about HD/SDA preferences was either'not applicable'or 'not answered'). (See Table 71).

Practice Administrators

There were very few of these and they were generally (talking here about one person, two person and three person centres' staff together) wholly or partly paid for by general practitioners. In the case of only one did the district pay the whole salary. In the case of only just over half of the practice administrators did the corresponding HD/SDA have a stated preference (most of the rest had entered a'not applicable'answer). Of the 16 for which there was a preference stated, for ten it was preferred that the general practitioner should pay some part and they did in fact always do so, and for six that the HD/SDA should pay all, though for only one did this in fact happen. (See Table 72).

Previous work experience of those with responsibility for the day-to-day administration of health centres

The interest here is both in the type or level of previous experience (for example whether nursing, administrative or clerical) and in the kind of institution where this experience was gained (for example, whether or not wihin the health services, and if so, in what kind of institution)

It should be noted that up to two previous job experiences were given by respondents to our questionnaires although many only indicated one form of experience, and some none at all - which does not necessarily mean that there was no previous work experience.

a) Skills involved in previous work experience

Considering first the type or level of previous experience, it is generally true that (apart from nurses and nursing officers with health centre administrative responsibility) almost none of the remainder had nursing experience of any kind (except for some practice administrators)

The senior health service administrators' previous experience tended to be administrative or supervisory in the nature of things - so interest lies in the kind of experience of the local (i.e. based in health centres) administrator. We have used a hierarchy in classifying experience for this purpose (see Table 73). The classification is as follows -

Administrative/supervisory experience - persons having such experience together with possibly other experience such as that of receptionist, secretarial or clerical or 'other' but excluding nursing from this category.

Reception experience - this is someone who has this form of previous experience with or without clerical and secretarial experience or 'other' but excluding those who have nursing or administrative or supervisory experience.

Secretarial and or typing and or clerical experience - those who have this experience together with 'other' experience but not administrative/supervisory, nursing or receptionist experience.

About a quarter of the 'health centre administrators' but very few of the other local administrators of health centres, such as secretary/receptionists, clinic clerks/clerks had administrative/supervisory experience (and local administrators in one person centres were more likely to have administrative/supervisory experience than those in two or three health centres taken as a whole).

Predictably, the majority of the clinic clerks/clerks previous experience was that which we classified as secretarial or typing or clerical, though there were a few with reception experience or 'other' experience.

Secretary/receptionists contained the highest proportion of staff who had reception experience, but otherwise their experience was mostly that classified as secretarial, typing and clerical with some 'other' experience.

The relatively few practice administrators seem to include a wider diversity of previous experience - nearly a quarter having some nursing experience and a similar number administrative/supervisory experience. Relatively few had reception experience (with or without administrative/supervisory or secretarial experience).

b) Whether previous work experience included working in the health services* (including general practice)

The answer to this question will in part depend on whether the person has held another post (prior to the present one) in the health services. Some people may have been in the same post for some years - particularly perhaps G.P. employed staff who have limited opportunity for movement and promotion within a particular practice organisation. Again, the more senior the administrator in the National Health Service, the more likely that he would have held a previous post in the National Health Service. Thus, for example, most of the sector administrators had had previous working experience of the health services in an earlier appointment.

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* Health services experience is counted only when this is definitely indicated from the job description.

Seventy-one per cent of hospital and unit administrators had had experience of health services in a previous appointment, 36% of clinic clerks, and hardly any of thr domestic supervisors and cleaner/caretakers. Otherwise about half of the administrators in any category had previous working experience of the health services. Generally speaking those with responsibility for day-to-day administration of one person centres were more likely to have had previous working experience in the health services than those in two and in three person centres, (See Table 74).

c) Type of institution where staff had previously worked.

Staff were classified according to the type of institution in which they had previously worked (Tables 75 & 76). This, of course, also presented difficulties as the information given in the questionnaire did not always enable us to clearly determine the institution in which the person had worked. For example, in a number of cases it was clear that a person had previously worked in local government but not clear whether or not this was in the health department. Apart from those whose previous experience was in local government (including those in the health department) there were some whose experience had clearly been in the hospital service, others clearly in the community health services and a residual group with health service experience whom we classified as 'other health services'. This last included, for example, some who had worked in the ambulance service and others who had been trainee administrators, (the extent of the latter's hospital service was not known but probably limited) There were others where all that was known was that they had worked in the health services in some way

In the sections that follow, we first examine the previous experience of occupants of various job types within the health services and local government. Then we go on to look at other experience outside these sectors, for those with and without health service and/or local government experience. We do not generally distinguish between those working in one, two or three person centres except where there was some noticeable difference - usually the numbers within job title categories were too small for such comparisons to be made.

(i) Experience within the health services and local government

Generally previous experience indicated was only in one part of the health service and/or local government but where experience in more than one part was indicated (see above), it is shown in the table. (See Table 75).

Sector Administrators

No sector administrator was reported to have any previous experience in the general practice sphere but about 8% had previous experience in the community health services, and a further 30% in local government (mostly, definitely to do with health services). Forty per cent had experience in hospital services only and the rest were nearly all in the 'other health services' category

Community Services Administrators

No administrators of this type had previous experience in general practice. Four per cent had previous experience in community health services while a further 50% had local government experience (though for most of these it was not indicated whether or not this was within the local health department). Twenty-five per cent had hospital experience only and almost all the rest had 'other health services' experience only.

Miscellaneous Administrators.

No one in this category had previous experience in general practice and only one out of 110 in community health services. However just over 50% had local government experience although as with community services administrators, for the most part it was not clear if this was in local health departments. Fifteen per cent had had hospital experience only, and 10% 'other health services' experience only. Twenty per cent of this group of administrators had no health service or local government experience or no answer was given about their previous experience. (This was unlike sector administrators and community service administrators where nearly all of these officers had had previous experience in the health services and/or local government)

Hospital and Unit Administrators

None of these had any experience in the general practice or community health service spheres. Some 60% had previous experience in local government (though mostly it was not clear whether this was to do with health). Just under 20% had hospital experience only and the same percentage 'other health services' experience only. Only one out of 37 did not have some previous experience of health services and/or local government reported.

Health Centre Administrators

Twelve per cent of these had had experience in general practice and a further 10% in the community health services. In addition 32% had had local government experience (for only a proportion of these was it definitely known that they had experience in health departments). Eleven per cent had had hospital experience only and 10% 'other health services' experience only. Twenty-four per cent had had previous experience entirely outside the health service and/or local government sphere (or at least none was indicated in the questionnaire).

Practice Administrators

Nineteen per cent (five out of 27), had experience in previous jobs in general practice but no one had experience either in community health services or local government. Thirty-three per cent had experience only either in hospital or more often in 'other health services' and just below half had no previous experience reported in health services and/or local government.

Secretaries and Receptionists

Twenty-two per cent had previous experience in general practice and a further 1% in the community health services. Twenty-one per cent had experience in local government (though it is not clear whether more than a handful of these had experience in health departments). Ten per cent had experience only in hospitals and 6% only of 'other health services'. Forty per cent had no experience reported in health services and/or local government.

Clinic Clerks/Clerks

Nine per cent had experience of general practice and a further 5% of community health services. In addition, 40% had previous experience in local government although only very infrequently was it indicated that this was in a health department. Five per cent had experience only in hospitals and 6% experience only in 'other health services'. Forty one per cent had no reported previous experience in health services and/or local government.

Nurses, Health Visitors, Nursing Officers

In the nature of things, all these staff would have experience of the health services in previous appointments and in particular of hospitals. It appeared that, in addition, about a quarter had experience either of general practice or of the community health services and/or of local government.

Cleaners/Caretakers

None of these had any reported experience in general practice or in the community health services, although eight had previously worked in local government. Otherwise one(out of 30) had hospital experience and there were none with any 'other health service' experience. The remainder (70%) had no reported experiences in health services and/or local government.

Domestic Supervisors

Predictably none of these had any previous experience in general practice or community health services. Three, however, had experience in local government and five in hospital, the remaining 20 had no reported previous experience in the health services and/or local government.

(ii) Previous work experience other than in the health services and/or local government

We have classified this experience in the following way. Experience in:- armed forces, nationalised industry, other public services (outside local government), private industry and other. (See Table 76).

Generally speaking, only very infrequently was work experience outside the health services and/or local government indicated by the respondents, not at all in fact for sector administrators, domestic supervisors and nurses. In total, previous experience in the armed forces was indicated for 29 staff including one also with experience in private industry (out of a total of 903 staff under consideration); previous experience in nationalised industry for three, including one with experience also in private industry; previous experience in other public service, 21; private industry 34, in addition to the two previously mentioned; and 'other' by 10. In total 107 out of the 903 staff under consideration had work experience outside the health service and/or local government indicated.

The bulk of those with no experience outside the health services and local government recorded had no health service or local government service recorded either. This was perhaps predictable in the sense that respondents to this open question gave at most two previous jobs. Thus they would presumably tend to omit (or be unaware of) previous experience, which was more distant than perhaps the last one or two health service and/or local government jobs.

One hundred and fifty six staff had no previous job or none was stated (mostly the latter). One reason for no previous job experience being indicated was simply that the responding officer in the district or area office (in the case of single district areas) would not have any reason to know about the previous work experience of say, general practitioner employed staff. This would explain the relatively large numbers of secretaries/receptionists and practice administrators where no answer was given in relation to previous work experience, and also some health centre administrators and clinic clerks. It would not however explain the lack of information about domestic supervisors and miscellaneous administrators.

Those with previous job experience of some kind outside health services and/or local government represented quite small proportions for all job types. For health centre administrators, the proportion was 17%; practice administrators the proportion was 26%; secretaries/receptionists the proportion was 13%; clinic clerks/clerks the proportion was 14% and cleaner/caretakers the proportion was 24%.

To whom were those with day-to-day responsibility for the administration of health centres directly accountable?

Respondents were asked to indicate to whom those listed as responsible on a day-to-day basis for health centre administration were directly accountable - in particular whether they were directly accountable to a health centre house committee, the general practitioners in the health centre, an administrator in the 'district'(or 'area' for single district areas) or some other person. Where the person indicated was an administrator in the district (or area) or some 'other person', respondents were asked to supply further details.

One person centres

Ninety one per cent of those responsible for the day-to-day administration of health centres were reported to be directly accountable to an administrator in the district (or area), six per cent to general practitioners (virtually all of these staff were employed by general practitioners) and the remainder to 'others' - one was said to be directly responsible to a health centre house committee. (See Table 77)

The group accountable to general practitioners included virtually all the practice administrators and was otherwise made up of 10 health centre administrators (out of 208), 10 secretaries and receptionists out of 64 and one clinic clerk. Most of the staff accountable to 'other' persons were nurses.

Turning to the question of the administrator in the district or area to whom the person responsible for the day-to-day administration of the health centre was accountable, interest focuses primarily on the staff based at the health centre level. More senior staff elsewhere were predictably accountable to an assortment of superior officers within the NHS. Among those titled 'health centre administrator', nearly half were directly responsible to a sector administrator and a further quarter to a community services administrator or his assistant. The remainder were accountable to a wide variety of officers but among these a proportion were senior officers such as assistant district administrators or operational service managers, whilst others were accountable to a relatively junior officer such as a general administrative assistant (function unspecified) or 'administrative assistant'. It would appear that health centre administrators were generally either directly accountable to a senior officer about the sector administrator level or to a community services administrator below that level but with specialist responsibility for community services. Rather similar remarks apply in the case of

secretary/receptionists or clinic clerks/clerks with day-to-day responsibility for running the centre (apart from those who were directly responsible to the general practitioners). However they were more likely to be accountable to a relatively junior officer. (See Table 78)

Two person centres

A rather lower proportion, 69%, than was the case in one person centres of those with day-to-day responsibility for the administration of health centres were directly accountable to an administrator, (district or area) and relatively more were accountable to general practitioners, 13% and 'other' persons, 22%. No one was accountable to a health centre house committee. (See Table 77). The relatively much larger 'other' category is partly due to the greater number of nurses relatively speaking involved in the administration of two person centres. However in these centres cleaner /caretakers tended to be accountable to 'other' persons rather than an administrator and so did one third of the domestic supervisors, a category of staff which did not feature in the administration of one person centres. Curiously, the increased proportion of those who were accountable to general practitioners was not explained by a corresponding increase in the proportion of those who were staff employed by the general practitioners.

Turning to the administrator or 'other' person to whom those with the day-to-day responsibilities for health centre administration were directly accountable , the relatively few health centre administrators were accountable to less senior administrative officers than those with the same title in one person centres. The converse was the case amongst secretaries, receptionists and clinic clerks (excluding those directly accountable to general practitioners). (See Table 79).

In the case of two person centres, we see the emergence in much greater numbers of functional staff - nurses, domestic supervisors, cleaner/caretakers - among those with the day-to-day responsibility for health centre administration These staff tended to be responsible to superiors in a specialised area, for example, a nursing officer or a domestic services manager, rather than to an administrator in the general hierarchy. Many of these functional superiors were included among the 'other' person category.

Three person centres

Sixty per cent of those with responsibility for day-to-day administration of health centres were accountable to an administrator in the district or area, 22% to 'other' persons and 13% to general practitioners. (See Table 77). (No answer was given in respect of the remaining 5%) The numbers involved in the case of the three person centres are relatively small but as in the two person centres, a relatively high proportion of the staff accountable to 'other' persons were nurses accountable to nursing officers.

The remainder of those accountable to 'other' persons were spread over several categories. As in one or two person centres, a number of those accountable to the general practitioners were employed by the general practitioner but four out of the thirteen three person centres were employees in the district.

Turning to the type of administrator or 'other' person to whom those with administrative responsibility for health centres who are based in the centres were responsible, it appears that as in the case of two person centres, the secretary/receptionist or clerks and clinic clerks were likely to be accountable to a more senior officer (where they were not accountable to the general practitioner themselves) than those so styled with health centre administration responsibilities in one person centres. (See Table 80).

Comment

It is clear that those responding to the questionnaire in respect of this question differed in their interpretation of 'administrator' in the district or area - in particular some, in fact a minority, regard a senior nursing officer or a domestic services manager as falling into this category, whilst others classified these as 'other' persons.

Regular meetings with other staff in the district (or area) in single district areas

For administrators of health centres based in a centre, meetings with other district staff (or area staff in the case of single district areas) can provide a link with the wider health service. So it was of interest to see whether in fact health centre administrators, practice administrators, secretaries/receptionists and clinic clerks/clerks with the day-to-day responsibilities for the administration of health centres did attend such meetings. (See Tables 81 and 82).

Generally in one person, two person and three person centres, about half the 'health centre administrators' attended at least one meeting; and no practice administrator did so. Fourteen per cent of the secretaries/receptionists and 28% of the clinic clerks/clerks in one person centres attended such meetings but hardly any of these staff did in two and three person centres.

Taking all four categories of centre based staff with health centre administrator responsibilities together, it is clear that those in one person centres were much more likely to attend meetings in the district (or area) than those in two or three person centres. (Perhaps this is because in two and three person centres, the locally based health centre administrator is often associated with one or more colleagues centrally based and it is these latter who attend the meetings in the district)

A wide variety of types of meetings were mentioned by the respondents but those to which reference was most commonly made were as in Table 82.. The most commonly mentioned meetings were ones specifically for administrators/supervisors and secretaries of health centres; followed by meetings of sector staff and meetings of unit administrators. Also mentioned were meetings of community health service administrators, meetings of district staff and 'multi-disciplinary' meetings.

Role on health centre house committee of persons responsible for the day-to-day administration of centres

There was a health centre house committee in 53% (300) of centres where one person was responsible for administration; in 25% (33) of centres with two persons responsible and in only 15% (5) of the 33 centres with three persons responsible.

One person centres with a house committee

The most active role on health centre committees appeared to be taken by health centre administrators. Two thirds of them were secretaries to the committee and only 5% had no role at all on the committee. Out of all the persons mentioned as secretaries to the committee, three quarters were health centre administrators. Only 5% out of all the persons responsible for administration in centres acted as chairmen or convenors for the committee. Either all these committees had no 'chairman' figure therefore, or that role was taken by someone not responsible for administration, for example, this might be a general practitioner. The type of persons responsible for administration who were least likely to have a role on the committee were 'miscellaneous' administrators and clerical staff. (See Table 83).

Two person centres with a house committee

In these centres (33 out of the 133 'two person' centres) over half the persons responsible for administration did not mention having a role on the house committee (compared to a fifth in 'one person' centres). No clear pattern of roles emerges, except that the secretary of the committee was mostly from outside the health centre (10 out of 14 secretaries) and there were only three 'chairmen' among all those mentioned as responsible for administering the two person centres with committees. (See Table 84).

Three person centres with a house committee

Only five of the 33 'three person' centres had a house committee, and only nine persons were mentioned as having any role on the committee. (See Table 85)

The size and complexity of a health centre as factors affecting administrative arrangements

Measuring 'complexity'

The nature and size of the task of administering a health centre is likely to be affected by a number of factors (see Baker and Bevan (1975)). Among these would be the number of general practitioners working from the centre, the number of separate practices in which these were grouped and the range of services in addition to those conventionally associated with primary medical care. The variable 'complexity' was designed to provide a simple number which characterised the sum of such factors. It was calculated as follows:

the total number of general practitioners working from the health centre (not necessarily using it as their main surgery)
plus the number of separate practices working in this way,
plus the number of consultant specialties holding sessions at the centre,
plus the number of 'other services' (in addition to those normally to be found in general practititioners' surgery premises)

This yielded a variable which took values in the range 1 to 40 with an average value over the 710 health centres of 11.2. The contribution to the complexity value of the total number of general practitioners working in the centre was in the range 0 to 28 with an average value of 5.6. The contribution of the number of consultant specialties holding sessions at the centre was in the range of 0 to 10 (it will be recalled than an answer 'all specialties' was given the value of 'eight specialties') with an average of .6 per health centre. The contribution of 'other services' to the value of complexity, was in the range 0 to 9 with an average value of 3.0. The contribution to the complex variable of the factor total number of practices, was in the range 0 to 9 with an average value of 2.0.

Number of General Practitioners and 'complexity' in relation to employment category of persons administering health centres

One person centres

Generally speaking the more general practitioners there were working from centres, the higher the proportion of centres (in a given range of size)

which were administered by health centre administrators of one of types* A, B and C. (See Table 86). This increase was largely explained by the increases in the proportion administered by administrators in employment categories B and C. The larger the health centre in terms of the number of general practitioners working from it, the less likely it was to be administered by a type D or type F administrator. There was no 'size' effect in respect of type E administrators or those employed by general practitioners (in employment categories G or H).

A similar result was found when the complexity measure is considered, in that the most 'complex' health centres using our measure were almost invariably administered by A, B or C type administrators. (See Table 87).

Two person centres

Here the type of administrative arrangements appeared to be relatively independent of the numbers of general practitioners working on the centres. (See Table 88 and 89).

Three person centres

Curiously these centres more closely resembled one person centres than two person centres as far as the effect of 'size' on type of administration was concerned. Thus the larger the health centre, whether measured by the number of general practitioners working from it or by its complexity, the more likely it was to have an administrator of one of types A, B or C and the less likely to have type D administrator - though the differences in relation to size of centre of these proportions were smaller than was the case for one person centres. (See Table 90 and 91).

Salary grades of administrators of health centres in employment categories A, B and C in relation to 'size' of health centres

One person centres

The larger the centre in terms of the number of general practitioners working from it, the more likely it was that the administrator where he/she was in one of the employment categories A, B or C would be on a salary scale of GAA or above at least for centres of up to about a dozen doctors. Larger centres than these were no more likely to have an administrator on a higher salary scale than those in the '9 to 12 general practitioners' category. This finding was generally true for

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* i.e. Employment category (see page 54)

administrators in each of the employment categories A, B and C, but the gradient of the increase was steepest in the case of administrators in employment category A . This might be expected since the duties of officers in employment categories B and C by definition extended beyond the single health centre . Thus they tended to be relatively often on higher grades (GAA and above) even where at least one of the centres they administered had relatively few doctors practising from it. (See Table 92).

As the 'complexity' score of a centre increased so it was more likely that the administrator (for those in employment categories A, B or C) would be on the salary grade GAA or above - at least up to centres of complexity score about 20 . For centres with higher complexity scores the proportion of centres with administrators in these higher salary grades levelled off. These results were almost entirely explained by the association of the salary grades of administrators with complexity of centre for those in employment category A. There did not appear to be any relationship between the complexity score and salary grade of administrators for centres with administrators in employment categories B and C. (See Table 93).

Two and three person centres

There was no evidence of an association of level of salary grade of administrators with numbers of general practitioners practising from a centre or with the complexity score of a centre in the case of administrators in any of the employment categories A, B or C.

Summary of comments by respondents on particular successess and difficulties in the health centre administration policies of their HD/SDA

HD/SDAs were invited to make comments about successes and difficulties they had in administering health centres which could be useful to others. Ninety HD/SDAs made some entry in response to this question. (Questionnaire A, Question 14). The answers by respondents are given in full in Appendix II.

The organisation in the district or area concerned with running health centres.

Nineteen HD/SDAs gave some view on the systems they had for administering health centres.

Problem areas mentioned included:

i) Co-ordinating services

ii) Communication between different administrative levels.

iii) Functional management structure, resulting in trivial matters needing much consultation.

iv) Area based services not 'meshing in' with district needs.

v) Lack of information on performance

Some recommendations made included:

i) A sector administrator holding most of the community budgets as "This enhances his ability to manage within a defined area".

ii) Having regular meetings of sector or relevant staff to discuss community services and any problems arising.

iii) Allowing health centres to evolve 'organically' and individually, avoiding over-administration and the imposition of a stereo-typed system.

Conflicting views were expressed about having community or geographical sectors. The geographical sector system was said to give experience of both hospital and community health to administrators. On the other hand, it was also said that having a community sector gave community services a stronger position against the claims of other sectors than would be possible in a geographical system.

Administration within the health centre

Three preferred ways of handling administration in the health centre were mentioned. Firstly, having an officer based in the centre (whether called an administrator, supervisor, clerical officer etc.) was particularly advocated by eleven HD/SDAs on the grounds that such a full-time presence

was vital for maintaining day-to-day administration. Secondly, two HD/SDAs were against an administrator based in the centre, preferring a 'middle' manager supervising several centres on a geographical basis. Thirdly, two HD/SDAs preferred the general practitioners to appoint a practice manager.

Ten HD/SDAs endorsed having house committees in centres as a means of resolving problems arising between the HD/SDA and the users of the centre.

The relationship between the HD/SDA and the general practitioners

Several aspects of relationships with general practitioners in health centres were raised by respondents, including finance, employment of reception staff and 'integration' generally.

a) Financial arrangements

Six HD/SDAs reported difficulties in agreeing charges with the general practitioners, especially when changes needed to be made for instance when premises were improved or extended. A few HD/SDAs said that deciding early on the apportionment of charges -before the opening of the centre - had been successful. One suggested that a nationally agreed formula for charges to doctors could be drawn up, just as allowances etc. to general practitioners are set out nationally.

b) Who should be the employer of reception staff and health centre administrators

Some definite views were expressed on the desirability of having the HD/SDA as the employer of the reception staff. Seven HD/SDAs felt this arrangement was certainly the best and the reasons given included interchangeability of staff for relief cover, common conditions of service, training and salaries for staff and the concept of total health care services. However one HD/SDA reported problems where general practitioner receptionists were employed by the HD/SDA because the staff had divided loyalties and the general practitioners felt that they had lost control of their staff. Five HD/SDAs were specifically against the health centre administrator or equivalent being paid for jointly by the health authority and the general practitioners on the grounds that this led to divided loyalties and made accountability difficult. (One other HD/SDA did report a successful joint appointment).

c) Integration

Several HD/SDAs were concerned about integrating the general practitioners with the health authority staff and services in the health centre. They felt that general practitioners, who were used to working in isolation and having control of their own staff and systems found it difficult to adapt to health centres. One HD/SDA referred to the 'island' mentality of general practitioners.

There were a number of suggestions on how to create or maintain good relationships with the general practitioners in the health centre, and these included the following:-

i) involving the general practitioners early on in the planning of the centre;

ii) involving general practitioners in the appointment of staff for the centre;

iii) ensuring that general practitioners are informed by letter or verbally about developments as they are often too busy to attend meetings, for instance House Committees;

iv) having primary health care records available to all team members;

v) focussing loyalty on the primary health care team, to avoid conflicts between the general practitioner and the HD/SDA,

vi) encouraging staff to use the common room for coffee and lunches;

vii) providing courses for general practitioner reception staff when they come into the centre, to help integration of administrative staff and understanding of the health centre concept;

viii) generally not being doctrinaire about administration, putting good relationships with general practitioners before complete administrative control.

Design

Several HD/SDAs commented on design aspects. Two felt that examination rooms, particularly at the ratio of one per general practitioner consulting suite, were wasteful. Problems mentioned included inadequate car-parking space, poor soundproofing, and difficulties in patient-calling systems. One HD/SDA had overcome lack of privacy at the reception desk by a system of "staggered" reception hatches instead of one long counter. Five HD/SDAs drew attention to a more general problem - that as services expanded and new services developed, the health centre could not provide enough accommodation for all the demands made upon it. This led to conflict between competing users. (However this expansion of use of the health centre could be interpreted as a sign of success). One HD/SDA emphasised the need to establish contingency plans for the vicinity of the health centre, with the local authority.

Widening the use of health centres

Several HD/SDAs said that wherever possible they encouraged maximum use of their health centres. Although in most cases this meant encouraging use by hospital consultants, PSWs. and other 'health' type services, some HD/SDAs went further and felt that centres should be used as much as possible, including in the evenings, for health education and related activities. One dissenting note on this came from an HD/SDA which felt that demand for use in the evenings was excessive and expensive in terms of providing heating and lighting.

Chart of employment categories[1] used in characterizing health centre administrative staff

Employment category type	Characteristics of employment category			Main groups of employment categories
	Employer of administrator	Location of administrator	Responsibilities of administrator	
A	Health authority	A health centre	Administration of one health centre	Administrative staff based in a health centre and so usually 'on the spot' and employed by the health authority.
B	Health authority	A health centre	Administration of two or more health centres, but not of any other premises or service.	
C	Health authority	A health centre	At least one health centre plus at least one other health service facility such as a G.P. hospital or clinic premises.	
D	Health authority	A health centre	Administration of one health centre in addition to other normal duties, e.g. as a health visitor or clinic clerk.	
E	Health authority	Not in a health centre but e.g. in a local hospital	Administration of a unit combined with administration of at least one health centre.	Administrative staff not based in the health centre, who visit the centre for administration, employed by the health authority.
F	Health authority	Not in a health centre	Administration of a sector combined with administration of at least one health centre.	
G	General Practitioner	A health centre	Administration of the health centre, possibly with some duties for the G.Ps. alone	Administrative staff based in the health centre and employed by the G.Ps.
H[2]	General Practitioner	A health centre	Administration of the health centre combined with duties for the practice, e.g. as a medical secretary or practice nurse.	
I[3]	Other arrangements			

[1] These categories correspond to those in Question 3 in Questionnaire A and Question 8 in Questionnaire B. They are the categories referred to when administrative arrangements for health centres preferred by health authorities, or employment arrangements for health centre administrative staff, are mentioned.

[2] In Questionnaire A there was no separate category for H, which is there in effect included under G.

[3] In Questionnaire A category I was simply referred to as 'other ways preferred'.

DISCUSSION

D.H.S.S. Guidance and other recent recommendations[1] on the day-to-day administration of health centres

The D.H.S.S. Circular[2] issued in 1979 gave the following advice on this matter:-

'Health Centre Administration and Management.

> In small health centres it will usually be sufficient if a suitable person, preferably a lay person, is charged with the responsibility for the day-to-day running of the health centre, e.g. preparation of office staff rotas, co-ordination of on-site domestic services in accordance with domestic services operational policy. This type of work can be undertaken by a senior receptionist secretary or administrative officer. In larger health centres it may be advisable for an Administrator to carry this responsibility especially during the first few months when he will be able to assist in the organisation of the centre. After this initial period he may be able to leave a senior receptionist or secretary at the health centre to cover the day-to-day organisation of the centre whilst retaining overall responsibility and visiting as appropriate.'

This guidance is unclear on a number of points. Firstly 'size' of health centre is not defined. In an earlier section of the same Circular (paras. 18 and 19) size is discussed in relation to the building of health centres, and is seen as a function of the number of general practitioners practising from the health centre as their main or sole surgery. The Circular recommends three general practitioners as a minimum and twelve general practitioners as a maximum (unless there are special reasons for smaller or larger numbers of general practitioners being accommodated). This then is the only idea given of what is meant by a small or large centre. However defining health centre size in terms of numbers of general practitioners leaves out two other factors, namely the number of practices and the scope of other services in the health centre (page 47).

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[1] Earlier recommendations were discussed in previous reports:-

G. E. Baker and J. M. Bevan (1975) Management & Administration of Health Centres, HSRU Report No. 13.

G. E. Baker and J. M. Bevan (1978) The Management & Administration of Health Centres - A study of the effects of the 1974 Reorganisation of the N.H.S., HSRU Report No. 33.

[2] Circular HC(79)8 Health Services Development: Primary Health Care: Health centres and other premises. Paragraph 67.

Secondly the Circular is imprecise about the type of administrative arrangement appropriate for health centres, large or small. In small centres it suggests a senior receptionist or administrative officer. In large centres it recommends an 'Administrator' taking an overall responsibility but delegating day-to-day organisation to a senior receptionist or secretary when the health centre has been in operation for a few months. Although it is not stated, it can be inferred that the 'Administrator' suggested is not based in a health centre, so for larger centres then the Circular suggests dividing day-to-day responsibility, but how tasks are to be divided is unclear.

Thirdly the Circular gives no guidance on a number of matters related to the employment of staff whose job is running health centres on a day-to-day basis. Some matters which need consideration are who should be the employer of these staff, the health authorities or the general practitioners; if the health authority is their employer, should the general practitioners contribute to the salary cost or vice versa; what is an appropriate salary grade; and are these persons to be fully occupied with health centre administration or to combine this with other activities.

Some other recommendations have also been made recently on how to organise health centre administration. Pritchard (1978)* feels that a 'practice manager' is inappropriate for small centres or surgeries but that larger more complex centres may require a manager.

> 'Primary health care is practised both from small surgeries for one doctor and from large city health centres with thirty doctors. Clearly it would be inappropriate to have a practice manager in the former, and it would be impossible to run a large health centre - particularly if it accommodated several practices - without one. Where along the scale of size does practice management require a specialist manager?
>
> In the small practice or health centre, usually one partner assumes the role of manager (with the agreement of his colleagues). He may delegate much of the day-to-day management to a senior secretary or receptionist, but will have to involve himself in most of the decisions, drafting letters, interviewing, fixing salaries, etc. It is unlikely that a small practice could afford the salary of a practice manager who did not do other duties.

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* Pritchard, P. (1978) Manual of Primary Health Care: its nature and organisation. Oxford: Oxford University Press.

> Some medium-sized health centres which have a large health authority element (child health, chiropody, speech therapy, and consultant clinics) may have a practice manager appointed by the health authority, who will be responsible for the authority's services and the building in which the practice operates. Within this structure the doctors may employ their own separate reception and treatment-room staff. In the larger centres it is likely that the practice manager will manage the general practitioner element as well. This has the advantage for the doctors that they do not have to worry so much about administrative details, but on the other hand they may have difficulty in ensuring that the service meets their needs, and that the staff all give a satisfactory service to the patients. They are less in control, but may in exchange have a very efficiently managed service.
>
> It all depends on the quality of recruitment and training to practice management, which at present is a low priority for development in the health service.'

There are three points of particular interest here. One is that Pritchard has recognised numbers of practices, and numbers of health authority services, as factors which have a bearing on the administrative arrangements needed. Another point is that he voices the anxiety of general practitioners that if administration in a health centre is in the hands of the health authority, the general practitioners may lose control over the administration, which may then not be conducted in a way they would like. Finally he mentions the need to seriously consider recruitment and training for practice management as a whole.

Beales (1978)* advocates a health centre 'manager' for every health centre, regardless of size, preferring one manager per centre rather than a manager responsible for two or more centres. He seems to have in mind a manager employed by the health authority, not the general practitioners, since he says that the most real authority a manager could expect is the supervision of receptionists if they are health authority employed. He also anticipates that general practitioners will be wary of any interference in running their own affairs.

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* Beales, G. (1978) Sick health centres and how to make them better Tunbridge Wells: Pitman Medical.

Various ways then of arranging the day-to-day administration of health centres have been advocated. These can be summed up in the following way:-

1. The responsibility for day-to-day administration to be given to a 'central' HD/SDA administrator not based in the health centre, but for instance in a hospital or in central offices, who liaises regularly with a contact (e.g. a clerk) in the health centre.

2. The responsibility for day-to-day administration to be given to a person based in a health centre. This could be -

   (i) a 'secretary' or administrator, employed by the health authority, who might also have responsibility for e.g. another health centre.

   (ii) a nurse, clerk, secretary etc. employed by the health authority who undertakes administration of the health centre in combination with their other duties.

   (iii) an employee of the general practitioners in the centre, e.g. a practice manager or secretary, who undertakes administration of the health centre either as full-time work or in combination with particular duties for the general practitioners.

Policy and practice in day-to-day administration for health centres according to the survey results

Administrative arrangements in health centres

Having a health centre based administrator was popular with HD/SDAs. Indeed about half chose this as the only way they favoured for administering a health centre. The next most popular arrangement, more particularly with SDAs, was arranging for a central or hospital based administrator to be responsible for the health centre.

The least popular single preferred arrangement was leaving the general practitioners to arrange administration. The remaining HD/SDAs favoured equally both health centre based and non health centre based types of person being responsible.

Generally HD/SDAs appeared to have the arrangements they preferred, except for some centres where the general practitioners had control, and this was not preferred by the HD/SDAs, and some who had centre based persons when HD/SDAs wanted central administrators.

Nearly two thirds of the centres in the survey had health centre based persons alone responsible for their day-to-day administration. Significantly, general practitioner employed staff were in a small minority (7%) of those with such responsibilities, so the move to a health centre does imply for general practitioners some loss of control over the administrative arrangements compared to being in their own premises. (In centres with two or three persons mentioned as responsible, general practitioner employed staff were more likely to have some responsibility for administration than they were in 'one person' centres

Size and complexity of the health centre and administrative arrangements

In our earlier report we had surmised that the numbers of services provided from the health centre, as well as the number of general practitioners practising there, could affect the type of administrative arrangement in the centre. The results of the survey showed that the greater the number of general practitioners practising from the health centre, the more likely it was that the centres would be administered by one person, based in a health centre, and employed by the health authority for that purpose. When 'complexity' of health centre is taken into account (i.e. other services, number of general practitioners and number of practices) the same pattern appears. This result shows a situation contrary to the advice given in the D.H.S.S. Circular referred to earlier, where it was suggested that the larger centres should have a more 'central' administrator responsible for them, who liaises with a receptionist or secretary at the health centre.

'Health centre administrator' type persons

The recommendations on administering health centres discussed earlier suggest various levels of staff, based in a health centre, as appropriate for the day-to-day administration of that centre, including secretaries, receptionists, practice managers and health centre administrators. The last named were more frequently mentioned than any other title for persons based in a health centre for its administration - 'health centre administrators' administered nearly a third (over 200) of the centres in the survey. This post of health centre administrator, as we had noticed in earlier reports, has become widespread as health

centres were built. It appeared also that at least another 100 staff with other titles, e.g. senior secretary or senior receptionist, filled a similar role, although they were usually on a lower salary grade.

Over a third of HD/SDAs with health centres indicated their only preference for health centre administration would be to employ a person based in the health centre solely for that work and a number of other HD/SDAs gave this arrangment as one of those preferred. Given that such posts are in existence, and that many HD/SDAs would like to have this arrangement, questions arise about the selection, training, career prospects and salaries of health centre administrators or their equivalents.

As regards selection, HD/SDAs with health centre administrator type posts thought that health service experience was desirable for staff taking up these posts and about half of these staff had clearly had such experience. A fifth of HD/SDAs with these staff thought that having, or studying for H.S.A. qualifications was desirable also. This qualification has become more relevant since there has been a unified administrative structure for the N.H.S. following the 1974 reorganisation, and has implications for career opportunities in the N.H.S.

On career possibilities for health centre administrators, a third of HD/SDAs thought health services administration generally would be appropriate, and another quarter took a more limited view, seeing administration in community health services as most appropriate.

Policy on training varied. Of those HD/SDAs who gave information on training for staff, about a fifth said they had no training courses at all, but nearly a half did provide some type of management course for staff in post. Clearly if health centre administration is to be seen as a career post, then studying for relevant qualifications, and having training, become important.

Regarding salary grades for persons titled health centre administrators, almost half of them were on GAA grade, over a third on HCO grade and a twelth on SAA grade, accounting for 93% of these staff. Generally, health centre administrators were on salary grades preferred by HD/SDAs for health centre administrator type posts, so presumably they were usually paid at levels of salary

which HD/SDAs felt to be appropriate. Persons designated as 'senior secretary' or 'senior receptionist' were mostly on HCO grades. Some differences in grades could be accounted for by the differences in responsibility between different posts. Of course many staff, and their salary grades, would be 'inherited' from the previous local health authority administration.

Giving health centre administrators wider responsibilities was a factor in determining salary grades, as well as the number of general practitioners and/or services in the health centre. These responsibilities may include administration of more than one health centre, administering certain local community clinics or administration of a nearby general practitioner hospital. Over a third of HD/SDAs selected having a health centre administrator with additional responsibilities as one preferred option for administering health centres and in fact a similar proportion of health centre administrators in the survey were employed on that basis. Staff designated senior secretary or senior receptionist hardly ever had these additional responsibilities. Similarly, health centre administrators were also very likely (in comparison with senior secretaries or senior receptionists) to act as secretary to the health centre committee, when these were in existence. Adding in to the job of health centre administrator more variety and responsibility in the ways mentioned above, is one method of increasing job satisfaction without actually promoting staff outside the health centre. This raises another issue - whether health centre administrator posts should lead to other positions or not, which is discussed next.

Broadly speaking, there are two approaches to appointing staff to health centre administrator type posts. One approach is to see these posts as a rung on the health services administration ladder, recruiting staff of an age and aptitude to pursue qualifications, who will probably not remain too long in the health centre, (indeed a couple of HDs in the survey used these posts for regional trainees). In this case, the HD/SDA needs to be prepared to provide training and promote staff. However this approach may not be so satisfactory for those working more permanently in the health centre, who may have to work with a rapid succession of administrators. This problem may be solved by the second approach, which is to regard health centre administrator posts as an ultimate position - which is the way the former local health authorities often regarded them. These posts would then be either

for clerical/reception/secretarial staff, or for older persons who had worked outside the health service and were near to the end of their working life. To be successful, staff recruited with this second approach in mind, would need to be happy to accept this more limited view of their job prospects, staying indefinitely in the same type of post.

Administrative Integration

One of the aims of the 1974 Reorganisation of the National Health Service was the integration of the three parts of the old N.H.S. which provided health services, i.e. regional hospital boards, local government health authorities, and executive councils, into a unified whole. How far, judging by the data received in the survey, was health centre administration integrated, both within the HD/SDA and the health centre? (This of course is no measure of integration of services).

One criterion of administrative integration for health centres might be how far administrators in the HD/SDA responsible for health centre administration had responsibilities for other services. Of these administrators, nearly two-thirds were solely concerned with administering community services. Most of the remaining third had responsibilities for administering acute, non-community services as well, and were therefore concerned with services for a 'geographical' area. (The tradition of having an administrative organisation specifically for community services remained, although this organisation might be a 'sub-sector' of a geographical sector system and could be part of a scheme designed for integration.

Another criterion of integration could be the degree to which administrative staff based in the health centre are, or can be involved in administration beyond the health centre itself. There is evidence that a proportion of these staff - about half the health centre administrators, an eight of the secretaries/receptionists and over a quarter of clerks - do attend administrative meetings in the HD/SDA. And many HD/SDAs did regard health centre administrator type posts as potentially leading to positions in other parts of health service administration, which would not have been feasible before the N.H.S. Reorganisation.

One way to encourage administrative integration within the health centre itself could be to have a health centre house committee. In HC(79)8, the D.H.S.S. recommended that health centres should have a committee for staff working in the centre, in addition to a medical practitioners staff committee.

> *'A Health Centre Committee should also be established to represent the interests of all staff (professional and non-professional) working at the centre. This Committee would usually have power to make rules where necessary covering minor day-to-day matters and should be consulted by the A.H.A. regarding any rules the latter may make concerning the management of health centres or the control of staff.'

Most HD/SDAs approved of having health centre house committees, however just under half the health centres in the survey actually had such committees. Centres were more likely to have committees where the HD/SDA approved of them. (Is this because these HD/SDAs encouraged setting up committees or because they approved of the committees already in existence?). Centres with a number of practices and/or a large number of general practitioners were also more likely to have committees - presumably these centres would need more formal means of discussing issues and communicating information.

The D.H.S.S. guidance states that the committee should 'represent the interests of all staff (professional and non-professional)' in the centre. What views did HD/SDAs take on who should be members of the committee, in the light of this guidance? They were strongly in favour of general practitioners (preferably a practice representative rather than all general practitioners) and a health centre administrator being members, and generally in favour of having a health centre based nurse, a nursing officer, and an administrative officer from the HD/SDA. However they were more divided on a receptionist representative - perhaps they felt this group were represented by the health centre administrator. HD/SDAs were not in favour of having a 'consumer' or patient representative either, which confirms the impression we had reported on in Phase 2 of these studies, that HD/SDAs were very wary of patient representation in health centres.

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* Circular HC(79)8. Health services development: Primary Health Care: Health centres and other premises. Paragraph 66.

General practitioners and the administration of the health centre

In our report of 1978, on Phase 2, we felt that general practitioners in health centres were becomming more isolated following the 1974 N.H.S. Reorganisation when health centres were transferred from local government health authorities to the new HD/SDAs. Certainly, judging by the comments of the HD/SDAs,they were concerned about the integration of family doctors within health centres, and they made suggestions on how to improve or maintain good relationships with general practitioners (see page 52). Although the survey was not concerned with assessing the integration of general practitioners within the centre, the results give some information about how far the general practitioners are involved in the administrative arrangements for running health centres.

As suggested in the preceding section, having a health centre house committee is one way of involving centre users in discussion and decision-making and HD/SDAs were both in favour of such committees and of having general practitioners on them. However the fact that half the health centres in the survey did not have these committees shows that this means of involvement was limited.

There was a limit also to the direct involvement of the general practitioners in the employment of the person appointed to administer the health centre on a day-to-day basis. Obviously where the person with this responsibility was a central administrator, such as a sector administrator, the general practitioners would have no say in their appointment. Less than ten per cent of the persons responsible for day-to-day administration of centres were employees of the general practitioner, the rest being health authority employees. However the general practitioners did contribute to the salaries of nearly a third of the persons responsible for day-to-day running in centres, where only one person was nominated. (Three-quarters of the centres were in that category). Presumably then the doctors could make a case for having a say in the appointment of persons to whose salary they contributed. However, even where general practitioners shared the costs of employing these persons, the persons themselves were almost invariably accountable to a health service administrator in the HD/SDA, and not to the general practitioners.

In contrast, the general practitioners employed their own reception staff in over 60 per cent of the health centres, although the greater the number of practices or general practitioners in the centre, the more likely were the reception staff to be employed by the health authority.

Unanswered Questions

This report has described the results of a survey of the policy and practice of HD/SDAs in England on the administration of their health centres. We cannot say from the results whether any health centre is 'well-administered' or whether any HD/SDA has an organisation which works well in administering its health centres. The survey has shown the variety of arrangements in existence, but cannot show whether any particular arrangement is better than another - we have been concerned to describe, not to evaluate.

The health districts and single district areas in their comments on their successes and difficulties, did not show a consensus in their solution to problems, although there appeared to be problems which they had in common. These included organising health centre administration within the HD/SDA efficiently, arranging effective administration in each health centre, and relationships generally with the general practitioners (see page 51). Given that one of the main aims of building health centres has been to develop co-operation between general practitioners and health authority services to provide team care for patients, it is significant that relationships between HD/SDAs and general practitioners in health centres, still seem to be problematic, at least as far as administrative arrangements are concerned.

What effects will the restructuring of the N.H.S., due to take place in 1982, have on administering health centres? One change which could have some direct effect on health centres is the abolition of the 'sector' and the establishment of 'units of management' as outlined in the D.H.S.S. Circular.* It was clear from the survey results that health centres were normally (as one would expect) administered within a sector, so the change to 'units of management' would have a direct bearing on the organisation in the district for administering health centres. The Circular states that the new 'units' should normally be smaller than existing sectors.

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* HC(80)8 Health Service Development: Structure and management

The Circular emphasizes the need for as much delegation as possible to the 'unit' level, both in decision making and budget control. The types of 'unit' suggested, e.g. for community services as a whole, for a large hospital, for a group of smaller hospitals with or without their local community services, are of course above health centre level. However if there is real delegation, it may mean more autonomy for health centres, with fewer decisions needing referral up a long hierarchy, which was a situation complained about in Phase 2 of our studies, and the health centre administrators, and the health centre house committees, having more real say in how health centres are run.

APPENDIX I

Letter A	Letter to Health Districts known to have health centres.
Letter B	Letter to Health Districts where it is believed there is no health centre.

(Similar letters were sent to Area Administrators of Single District Areas)

Questionnaire A	District Policy of administration of health centres.
Questionnaire B	Administration of individual health centres.

A

UNIVERSITY OF KENT AT CANTERBURY
HEALTH SERVICES RESEARCH UNIT

CORNWALLIS BUILDING
THE UNIVERSITY
CANTERBURY
KENT
CT2 7NF

DIRECTOR

PROFESSOR MICHAEL D. WARREN

TELEPHONE (0227) 66822

30th June, 1977.

Dear

We are writing to ask for your help in a study we are undertaking, supported by the Department of Health and Social Security, into the policy and practice of health districts in relation to the administration of their health centres. The study is in the form of a postal survey addressed to District Administrators (or Administrators of single District Areas) in England.

Two types of questionnaire are used in this survey, and these are enclosed.

Questionnaire A, of which one copy is enclosed, is about district policy on health centre administration - that is, the policy of the District Management Team or of the officer in the District to whom responsibility has been delegated. We should be grateful if you or the appropriate officer would complete this questionnaire.

Questionnaire B is about the administrative arrangements in individual health centres. We enclose one of these for each health centre in your Health District, with the name of the health centre written on the front page. We have added two spare, blank, copies of Questionnaire B in case there are health centres operational in your District which are not in our records. (Our information is taken mainly from the Hospitals and Health Services Yearbook for 1977). We should be grateful if you would arrange for these to be completed by the appropriate officer(s) (if more are needed, please let us know).

It would be very helpful if you could post both kinds of questionnaire back to us in the stamped addressed envelope provided by 22nd July.

/continued .....

A
C

We should be happy to provide you with a summary of the results of the survey. If this is of interest, please tick the box in question 16 at the end of Questionnaire A.

My colleague, Gail Baker, or I will, of course, be happy to answer any enquiries you may have on the questionnaires.

Yours sincerely,

JOHN BEVAN
Assistant Director

Enclosures

B

UNIVERSITY OF KENT AT CANTERBURY
HEALTH SERVICES RESEARCH UNIT

CORNWALLIS BUILDING
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CANTERBURY
KENT
CT2 7NF

DIRECTOR

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According to our information, based on the Hospitals and Health Services Yearbook for 1977, there are no health centres in your District. However, we have enclosed copies of the questionnaires as we realise that the Yearbook may be out-of-date or inaccurate. If, in fact, there are no health centres operational in your District, we would like to know whether or not any are being built and we ask you to answer just question 15 in Questionnaire A (see below) and return it to us, in the stamped addressed envelope provided.

If at least one health centre is operational in your District, both types of Questionnaire, A and B, apply fully.

Questionnaire A, of which one copy is enclosed, is about district policy on health centre administration - that is, the policy of the District Management Team or of the officer in the District to whom responsibility has been delegated. We should be grateful if you or the appropriate officer would complete this questionnaire.

Questionnaire B is about the administrative arrangements in individual health centres. We enclose two copies, with the space on the front page for the name of the health centre left blank. We should be grateful if you would arrange for this to be completed for any health centres operational in your District by the appropriate officer(s) - if more copies are needed, please let us know.

/continued .....

B
D

It would be very helpful if the questionnaires could be returned to us by 22nd July.

We should be happy to provide you with a summary of the results of the survey. If this is of interest, please tick the box in question 16 at the end of Questionnaire A.

My colleague, Gail Baker, or I will, of course, be happy to answer any enquiries you may have on the questionnaires.

Yours sincerely,

JOHN BEVAN
Assistant Director

Enclosures

Health Services Research Unit,
University of Kent at Canterbury

STUDY OF ADMINISTRATIVE ARRANGEMENTS FOR HEALTH CENTRES

QUESTIONNAIRE A:
DISTRICT POLICY ON ADMINISTRATION OF HEALTH CENTRES

..... Health District/Area

(1) Who in the district is (or are) directly responsible for the administration of health centres, e.g. a community services sector administrator or sector administrator for a geographical area? Please give the title (or titles) of the person (or persons) responsible.

.....

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(2) Does this person (or persons) have other administrative responsibilities for, e.g., other community health services, hospital services? If so, please state.

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.....

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.....

(3) Please indicate which is the way preferred in this district for arranging the day-to-day internal administration of its health centres. Please tick as appropriate, ticking more than one box if more than one way is considered equally acceptable.

(a) The district to employ an administrator (or equivalent by another name) whose sole responsibility is for a single health centre, and who is based in that health centre. ☐

(b) The district to employ an administrator (or equivalent by another name) whose responsibility is for two or more health centres, but not for other health services premises, and who is based in at least one of the health centres concerned. ☐

(c) The district to employ an administrator (or equivalent by another name) responsible for at least one health centre, with administrative responsibilities also for at least one other health service facility such as a local clinic or community hospital, and who is based in a health centre. ☐

(d) The district to arrange for a district employee such as a clinic clerk or health visitor who is based in a health centre, to undertake administrative tasks in that centre in addition to their other duties. ☐

(e) The district to arrange for a Unit Administrator, not based in the health centre but, for example, in a local hospital, to undertake day-to-day administration for a health centre. ☐

(f) The district to arrange for an administrator, such as a Sector Administrator or his assistant, not based in a health centre, to see to the day-to-day administration of one or more health centres, no person being employed by the district in the health centre for its administration. ☐

(g) The district to leave the G.P.s in the health centre to arrange for someone employed by the practice(s) to carry out day-to-day administration. ☐

Other ways preferred, please say what these are:-

.....

.....

.....

IF ARRANGEMENTS DESCRIBED IN (a), (b) or (c) IN QUESTION (3) ABOVE, ARE IN EXISTENCE IN YOUR DISTRICT, (i.e. THOSE WHERE THE DISTRICT EMPLOYS SOMEONE BASED IN A HEALTH CENTRE SPECIFICALLY TO UNDERTAKE DAY-TO-DAY ADMINISTRATION) WHETHER OR NOT THEY ARE PREFERRED, PLEASE ANSWER QUESTIONS 4 TO 8 BELOW. OTHERWISE GO ON TO QUESTION 9.

(4) What sort of backgrounds would be acceptable for these posts? E.g. secretarial, clerical, in armed forces, with or without experience in health services, with or without IHSA qualifications.

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(5) Please give details of any training which it is the policy of the district to give to:

(a) those staff newly appointed to health centre administrator posts

.....

.....

.....

(b) those staff already in a health centre administrator post

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.....

.....

(6) What, if any, career structure is seen for persons in these posts?

.....

.....

.....

(7) What salary grades are thought appropriate for these posts? (E.g. Higher Clerical Officer, General Administrative Assistant)

.....

.....

If more than one grade is thought appropriate what are the criteria for deciding on a grade for a particular post?

.....

.....

.....

(8) In this district, is it preferred to pay wholly for the salaries of persons based in a health centre and employed to undertake the day-to-day administration in a health centre, or to have some contribution from the G.P.s (reimbursed as appropriate)?

Please tick one.

District prefers to pay whole salary ☐

District prefers G.P.s to make some contribution to the salary ☐

District does not mind either way ☐

(9) In this district, is it preferred that the G.P.s or the district are the employers of the reception staff for the family doctors in health centres?

Please tick one.

District prefers to employ reception staff for G.P.s ☐

District prefers G.P.s to employ their own reception staff ☐

District does not mind either way ☐

(10) What are the arrangements preferred in the district for liaison, between the person(s) in the health centre responsible for day-to-day running and other officers in the district?

Person(s) in health centre responsible for day-to-day administration to liaise directly with functional officers, (e.g. in supplies, personnel, works etc.) ☐

Person(s) in health centre responsible for day-to-day administration to liaise with administrator in district (e.g. Sector Administrator) who will contact other, functional officers as appropriate ☐

Person(s) in health centre responsible for day-to-day administration to liaise with functional officers for some matters and administrator in district for other matters ☐

Other liaison arrangements preferred ☐

Please say what these are .....

.....

.....

.....

(11) How does the district regard having house committees in its health centres?

Please tick one.

Having health centre house committees is:-

Essential ☐

Desirable ☐

Not important ☐

Undesirable ☐

(12) How does this district regard the following for inclusion in the membership of health centre house committees? Please tick one box in each line below, as appropriate.

	Essential	Desirable	Do not mind	Undesirable
A G.P. representative from each practice in the health centre	☐	☐	☐	☐
All the G.P.s in the health centre	☐	☐	☐	☐
A Family Practitioner Committee representative	☐	☐	☐	☐
A district employed nurse (community nurse, health visitor or midwife) based in the centre	☐	☐	☐	☐
A nursing officer, not necessarily based in the centre	☐	☐	☐	☐
Health Centre administrator or equivalent person (if in post)	☐	☐	☐	☐
An administrative officer from the district/sector	☐	☐	☐	☐

Please give title of person thought appropriate

.....

A receptionist representative	☐	☐	☐	☐
A consumer (e.g. a patient or Community Health Council member) representative	☐	☐	☐	☐

Anyone else, please say:

.....	☐	☐	☐	☐
.....	☐	☐	☐	☐

(13) Does this district have a permanent or ad hoc health care planning team wholly or substantially concerned with community or primary health care services? Please tick one.

No ☐

Yes ☐

Please give title of team .....

(14) Are there any particular successes or difficulties in your health centre administration policies which you think could usefully be communicated to other districts? Please tell us about these.

.....

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(15) Are there any health centres being built in this district?

Please tick one.

No health centres being built ☐

At least one health centre being built ☐

Please give names of those being built

.....

.....

.....

.....

(16) Would you like to have a summary of the results of this survey when these are available?

Yes ☐

No ☐

Name and position of officer who completed this questionnaire:

.....

.....

Health Services Research Unit,
University of Kent at Canterbury

STUDY OF ADMINISTRATIVE ARRANGEMENTS FOR HEALTH CENTRES

QUESTIONNAIRE B:
ADMINISTRATION OF INDIVIDUAL HEALTH CENTRES

..... Health Centre

..... Health District/Area

(1) Year Health Centre opened .....

(2) Numbers of general practitioners and practices in the health centre.
Please complete each practice box as appropriate.

Practice	No. of Principals working mainly in health centre	No. of Principals working mainly outside health centre
1		
2		
3		
4		
5		

(3) Is the health centre adjacent to any of the following?
Please tick any which apply and add any not listed.

Other clinic premises ☐

G.P. hospital ☐

Other NHS hospital ☐

Please give name .....

Other NHS premises, please say what these are ☐

.....

.....

Not adjacent to any of the above ☐

(4) Does the health centre or any adjacent premises identified in Question 3 provide any services apart from those usually associated with the primary health care team?
Please tick any which apply, and add any not listed.

	In Health Centre	In Adj. Prem.		In Health Centre	In Adj. Prem.
School dental	☐	☐	X-Ray	☐	☐
General dental	☐	☐	Social work session	☐	☐
General ophthalmic	☐	☐	Consultant sessions	☐	☐
General pharmacy (this does not include dispensing by G.P.s)	☐	☐	Please say which specialties		
Physiotherapy	☐	☐			
Chiropody	☐	☐			
Speech therapy	☐	☐	Other services, please state		
Child guidance	☐	☐			

(5) Is there provision for a house committee in this health centre?
Please tick one.

Yes ☐

No ☐

(6) Who is the employer of the reception staff who work for the G.P.s in the health centre?
Please tick one.

The G.P.s employ them ☐

The district employs them ☐

It varies between practices ☐

IN THE LAST PART OF THIS QUESTIONNAIRE, QUESTIONS 7 - 14, WE ASK FOR INFORMATION ABOUT THE PERSON RESPONSIBLE FOR DAY-TO-DAY ADMINISTRATION IN THIS HEALTH CENTRE. ALTHOUGH WE EXPECT THIS TASK WILL OFTEN BE UNDERTAKEN BY ONE PERSON, WE HAVE ALLOWED FOR ANSWERS TO BE GIVEN FOR UP TO 3 PERSONS, PROVIDING SPACES AND BOXES AS APPROPRIATE, IF THIS APPLIES.

(7) Who is the person responsible for day-to-day administration of the health centre, (e.g. seeing cleaning is properly done, arranging urgent repairs)? Please give the title of this person (e.g. health centre administrator, practice secretary, clinic clerk). If these tasks are divided between more than one person, please specify who they are and, in outline, how they tasks are divided.

(1) .....

(2) .....

(3) .....

(8) Is this person (or these persons):

	1	2	3
(a) Employed by the district solely for the administration of this centre, and based in it?	☐	☐	☐
(b) Employed by the district for the administration of this and at least one other health centre, based in one of these centres, and not having any administrative responsibility for any other health service premises?	☐	☐	☐
(c) Employed by the district for the administration of at least this health centre, and with administrative responsibilities also for at least one other health service facility, but based in a health centre,			
Please tick any which apply			
administrative responsibilities in a G.P. hospital	☐	☐	☐
administrative responsibilities in one or more local clinic premises	☐	☐	☐
other responsibilities - please say what these are	☐	☐	☐
.....			
.....			
(d) An employee of the district based in this health centre such as a clinic clerk or health visitor, who undertakes administrative tasks in this centre in addition to their other duties?	☐	☐	☐
(e) A Unit Administrator, not based in this health centre but, for example, in a local hospital, who also undertakes the administration of this health centre?	☐	☐	☐
(f) An administrator employed by the district, such as a Sector Administrator or his assistant, not based in a health centre, who includes the day-to-day administration of this health centre among their duties?	☐	☐	☐
(g) Employed by the G.P.s wholly or mainly as administrator in the health centre?	☐	☐	☐
(h) Employed by the G.P.s and undertaking administration in the health centre in addition to other duties, e.g. as medical secretary or practice nurse?	☐	☐	☐
(i) Other arrangements - please explain	☐	☐	☐
.....			
.....			

(9) What is this person's (or persons') salary grade? (E.g. General Administrative Assistant, Higher Clerical Officer etc.)

(1) .....

(2) .....

(3) .....

(10) Who pays this person's (or persons') salary? Please tick as appropriate.

	1	2	3
The health district pays all of salary	☐	☐	☐
The G.P.s pay all of salary (with appropriate reimbursement)	☐	☐	☐
The health district and the G.P.s (with appropriate reimbursement) divide the cost of the salary	☐	☐	☐
If so, what proportion does the district pay?	...%	...%	...%
Other arrangements	☐	☐	☐

Please specify .....

(11) What type of background, or previous employment, did this person (or persons) have, e.g. school secretary, clerical officer in local government, officer in one of the armed services etc.?

(1) .....

(2) .....

(3) .....

(12) To whom is this person (or persons) directly accountable? Please tick as appropriate.

	1	2	3
The health centre house committee	☐	☐	☐
The G.P.s in the health centre	☐	☐	☐
An administrator in the district	☐	☐	☐
Please give his/her title			
Other - please specify	☐	☐	☐

.....

(13) Does this person (or persons) participate in regular meetings with other staff in the district, e.g. Unit Administrator meetings?

Please tick one.

No ☐ ☐ ☐

Yes ☐ ☐ ☐

Please say what meetings these are.

.....

.....

.....

(14) If there is a house committee, does the person (or persons) responsible for day-to-day administration (i.e. identified in question (7) above) have a role on the committee, such as secretary and/or member.

	1	2	3
No role in the house committee	☐	☐	☐
Some role in house committee	☐	☐	☐

Please say what this is .....

.....

.....

Name and position of officer who completed this questionnaire:

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APPENDIX II

This appendix reproduces all the answers given to Question 14 in Questionnaire A of the survey. (A summary of the answers is given in the report, see page 50).

Question 14 was "Are there any particular successes or difficulties in your health centre administration policies which you think could usefully be communicated to other districts? Please tell us about these".

Ninety HD/SDAs gave some answer to this question and these are reproduced below. Nos. 1-16 are answers from single district areas and nos. 17-90 are answers from health districts. All identifying names, for instance of health districts or health centres have been deleted, or replaced by an appropriate phase such as 'this health district' or 'in one health centre'.

1. We have found the existing arrangements work satisfactorily with the Sector Administrator and his senior admin. staff paying prequisite visits to health centres. Recently we have been prompted to think about developing a House Committee system in one of our new health centres.

Basically we adopt the philosophy of handling the arrangements at each unit to fit in with the local personalities rather than attempting to introduce a stereo typed committee system.

2. i) The structure should provide for comprehensive cover in the absense of the sector administrator.
ii) The link between community sector without any hospital involvement has been difficult to achieve other than on a personal basis.
iii) Inegration between different sections of the community activity at administrative level is achieved through monthly meetings.
iv) In commissioning new health centres it is essential to involve all prospective users especially general practitioners.

3. Communication is imperative. Many general practitioners using health centre premises are too busy to attend the House Committee Meetings. It is most important that they are kept informed of developments, either by letter or verbally from the Health Centre Manager. To a certain extent, general practitioners should be cossetted to ensure maximum patient care. This area has introduced, where possible, services enjoyed by the hospital into the community.

i) C.S.S.D. Service
ii) A. & E. Service where patients seen at health centre, rather than hospital casualty.
iii) Physiotherapist from hospital undertakes sessions at health centre.
iv) Hospital's dietician holds obesity clinics.
v) H ospital Consultants hold outpatient clinics in health centres as well as at base hospital.

4. We have six small health centres, the majority occupied by only one family doctor practice, none of which are large enough to warrant the presence of a resident administrator. We would find it helpful if we had one member of the A.H.A. staff (even on a basic clerical grade) to preserve a full-time presence in the health centre,

to deal with enquiries, deliveries of goods, programming of sessions and other general day to day problems.

As our health centre programme expands and we build larger health centres, we envisage the appointment of a higher clerical officer who would be directly responsible to the general administrative assistant previously mentioned.

Although we do not have Health Centre House Committees as such, we do hold meetings with health centre users to consult or discuss with them any matters which could have an effect on the use of the premises.

5. All appointments of staff to work in the health centre are mutually agreed with the general practitioners using the centre. This is usually arranged by a representative of the general practitioners attending any interviews and drawing up the short-list of candidates for interview with the community health services administrator.

6. There should be full integration between area and general practitioners in operational services, e.g. cleaning, telephones etc. More practices in health centres the more problems there are. Health centres better for patients - for accommodation. P.S.Ws. attached to health centres have been successful (two centres). Make sure records area large enough - practices always seem to grow. Health centres should be large enough to undertake wide range of activities including evenings, space needed for this (Health Education room). No need for examination room.

7. i) In some instances the team spirit between members of the general medical practitioners and community health services needs fostering.

ii) As the administrative officers responsible have community and hospital services responsibilities, there have been examples of health centres benefiting from local hospital resources. The integrated approach has clearly been of benefit in these instances.

8. i) It is most desirable for the Authority to employ all staff, including reception staff, working within the health centre, (excluding general practitioners). This provides for comparability of:-

Salary, terms and conditions of service, training, staff cover arrangements, such an arrangement is not always welcomed by general practitioners.

ii) We have found in a recently commissioned health centre that considerable problems in communication can arise out of short comings in the design stage. This is in terms of patient waiting areas, systems of calling patients into the surgery, system of contact between general practitioners and receptionists etc. Such communication questions are perhaps the most important aspects of the design and operation of a health centre.

9. i) Arrangements were made for AHA staff concerned with administration of health centres to be 'settled in' prior to phased entry of general practitioners and other services.

ii) Emphasis is placed on total involvement in the health centre by all concerned.

iii) House Committee concept has proven useful in ironing out Operational Policies.

10. The appointment of a scale 14 Administrator responsible fo the general administrator (operational services) together with 3 general administrative assistant grade managers for the three community health sectors had aided considerably the co-ordination of services which is the most significant problem in administering health centre and area policies. The reluctance evidenced naturally by general practitioners in operating from health centres is apparent in our Area as it is elsewhere in the country. Those in a high ratio of single handed general practitioner in this area (approx. 25%) which is also a factor to be considered when contemplating developing health centre provision.

Policies have also been aided by the Centralisation of Community Health Service support services e.g. Statistics and Community Specialist Staff who are based in the same headquarters as the scale 14 administrator.

Geographically this is a very compact single district area and this has enabled the administrator in his role of co-ordinator to bring together more easily the specialist advice and expertise necessary for the development of primary care services.

12. Before a Health Centre House Committee, the Chairman of the Committee (a senior general practitioner in all cases) is asked to call together local persons - nurses, health visitors, clinic clerks and reception rep. - together to put matters on agenda for House Committee comprising of A.H.A. and F.P.C. members to discuss and to ensure any specialist A.H.A. Manager to attend if a problem

exists in his field. If internal alteration is to be considered, the Area Building Officer would be asked. The secretarial work: Notice, Agenda, Minutes, and Correspondence are done by the staff of the F.P.C.

A Community Management Team has been created comprising:-

Administrator F.P.S. and C.H.S.	Divisional Nursing Officer (Community)
Divisional Nursing Officer (Midwifery	Community Physician (Child Health)
Area Chiropodist	Area Speech Therapist
Area Dental Officer	Health Education Officer.

Any other Area Officer is invited for a particular topic, e.g. Treasurer re. budgets; Building Officer re. alterations, maintenance etc. Any such officer may also ask to attend to raise a topic on which he wishes community advice.

The team meets monthly and is co-ordinated by the Administrator, FPS/CHS and a large part of its function is to discuss health centre administration in that it deals with planning and operational policy and any problems at health centres and clinics. The main difficulty experienced is the number of functional managers each guarding his or her own staff. This creates difficulties for administration at local level and there is a tendancy for much trivia which needs consultation to unnecessarily come for consideration at a senior level. I am attempting to create these lines of communication in the future at Zone and Health Centre level to prevent this happening.

13. It is not so easy to deal promptly with routine repairs and maintenance (as against emergencies) and general practitioners in particular have been used to securing prompt attention to such matters (e.g. through patient contacts using local tradesmen). General Practitioners therefore become frustrated more readily and the Administrator F.P.S. can often help to provide a safety valve (if necessary by acting as temporary contact point in particular instances) but should not be regarded as routinely involved in day to day administration.

Our most successful health centre is one where there is a full time <u>resident</u> caretaker. The work is , however, demanding and cost is high.

14. <u>Successes</u> Meetings of all health centre administrators

Close link between health centre staff and associated schools, peripheral clinics.

District staff are essentially based at health centres and liaise through health centre administrator.

GP Bulletin issued by area.

Area works, domestic, supply, loan equipment and courier services, have achieved an integrated atmosphere with other district services.

Facilities offered to and used by voluntary organisations.

Difficulties

An individual approach to each health centre problem has to be taken to recognise personality, community and professional traditions. The community services sector administrator has a particularly demanding job in organising these local variations of approach.

Original planning constraints on size of health centres has meant inhibition of some services and less than ideal conditions in certain respects has accrued in establishing method of defining criteria between acute hospital based services and community health centre services for both financial and manpower resources.

15. Difficulties are experienced in those health centres where general practitioners select and employ own receptionists - different rates of pay and conditions. Unwillingness of receptionist employed by one 'firm' to relieve another.

Unwillingness to take messages for other community staff, e.g. H.V.s., Receptionists are not always well selected and rarely well trained.

16. Such difficulties as arise come about mainly through personality differences. Any measure of success which we can claim is the ability to maintain good relations at most times with general practitioners who come into health centres with what one might call an 'island' mentality, ie. they have been accustomed to working in isolation and making their own rules, and the transition to operating in a building which might house twenty other people (some of different disciplines) is not easy.

17. Dividing the district into sectors gives the sector administrators experience in both Hospital and Community Management concepts; likewise in regard to the unit administrator who also manages a small hospital.

18. The situation in this district is that we have one health centre operational, involving four general practitioners, three of whom are in one practice, the fourth being based some miles away. Effectively it is a single practice health centre and does not call for sophisticated administrative arrangements.

In addition we have a major health centre for twelve plus general practitioners in an advanced planning stage. We envisage that this will call for a very different approach in day to day management and are prepared for a house committee but not for a designated administrator on the spot. We intend that health centres should continue to be managed within the community services of each geographical sector of the district under the sector administrator. We have not yet decided on the receptionist arrangements, but prefer that in a multi practice centre the N.H.S. should employ the receptionist and recharge the practices (of which there will be at least five).

19. Some difficulty, which may, in some ways be regarded as a failure, has arisen in a new health centre opened in 1977 where general practitioner participation was by one practice only, employing three doctors. The design brief was based on joint use of the Records/Reception area by general practitioner staff and community clerks. A common telephone system was installed, with a PABX switchboard operated by a community employee. It became quickly apparent that the practice were having difficulty in dealing with multiple calls from patients coming in from the four exchange lines, and in fact, were unhappy with the presence of community staff in the same area as their own receptionists. After discussion, the community staff have been withdrawn and the telephone installation reorganised, leaving the general practitioners with an independent line.

One aspect which is worthy of consideration is that every effort should be made to ensure full use of the health centre. It is vital that as much thought should be given to this as possible in the early design and planning stage. A commissioning team should be formed to advise planning teams in the initial period, not when the project is nearly complete.

Care should be taken to design according to use, not to desirable facilities, e.g. is it necessary for several doctors each to have separate examination room. The percentage time an examination room attached to a consulting suite is used leads one to the conclusion that the space would be better used in some other way, say in enlarging the consulting rooms themselves. One examination room could serve groups of doctors. There is a failure to ensure full use of accommodation, and more thought should be given to shared use.

There would appear to be some danger, where only one practice is involved, that the general practitioners and their staffs look on the health centre as no more than improved facilities for the practice, with a detrimental effect on joint users, or desirable integration.

20. It is considered essential that an officer (possibly higher clerical grade) should be based in a health centre of any size in order to ensure an efficient organisation. One of the health centres transferred from the local authority does not have an officer based in it and this can and does create problems. The difficult financial situation has not allowed us to change this.

Some confusion does arise by having sector administrators responsible for the day to day management of the health centre and at the same time having a senior administrative assistant based at District Headquarters. The latter is primarily responsible for the development of policy and oversight of the community services which are organised on a district basis.

The fact that senior community nursing staff are based at District does not encourage them to make contact with officers based within sectors. They have always been used to 'popping in' and seeing the senior officer responsible for community services.

21. Difficulties:

Where health centre 'administrator' salaries are shared on a 50/50 basis between general practitioners and district, there are divided loyalties and differing pressures on workloads. Joint appointments are not recommended.

Successes:

The creation of a functional community health sector for the whole district for administration and nursing purposes has achieved a uniformity of approach to all health centres. By being

an entity of some size, there has been no difficulty in establishing effective relationships with the hospitals, and this together with the inclusion of the two community hospitals within the sector, has assisted the integration of hospital and community services within the district. By being a separate sector, however, community services, including health centres, have had a much more effective voice in the affairs of the district, than would have been the case if they had been linked with hospitals on a geographical basis.

22. Input to planning through administrator, community health services and community based members of other Health Care Planning Teams.

23. The policy of employing one administrator based in District Headquarters is felt to be the most suitable arrangement. He/she is in a position to co-ordinate the community health services run from the various centres and is also in the best position to liaise direct with the various other functional officers in the district regarding the needs of the centre, and the administrator, Family Practitioner Committee, in relation to the general practitioners working from the centre.

24. Difficulties have arisen in the past with communications because of the large geographical area. It is hoped, however, that under the new arrangements, i.e. local unit administrators being responsible through the sector administrators for the day to day administration of these units, that this problem can be overcome.

Where Health Centre Committees have been started they have proved invaluable.

25. The appointment of a community health services administrator is most satisfactory because he covers the whole district. His most senior member of staff is higher clerical in a large health clinic in a neighbouring town (9 miles away). She will most likely act as deputy in the course of time.

26. The maintenance staff responsible for health centres and clinics are radio-controlled from the District Works Department. In a widely scattered situation, this facilitates supervision and ensures prompt attention to repairs.

27. i) The appointment and payment of Clinic Receptionist by GPs. is seen to erode the concept of a total Health Care Service and allow for the development of preferential services in certain clinics.

ii) There is seen to be clear advantages of developing multi-disciplinary staffing relationships within individual clinics. Also in having an A and C grade officer permanently based in each premises.

28. Administration

Over-administration is a bad thing. Health Centres should be encouraged to evolve organically, every change being made in full consultation with the practitioners.

Loyalties

The over-riding loyalty should be to the primary health care team - such a focus is a good substitute for the AHA versus GP syndrome.

Finance

Practice and other allowances to GPs are nationally agreed; why not then the formula for charges and their apportionment?

29. The Committee arrangements at the new Health Centre have proved to be of value since they provide for a liaison committee upon which are representatives of all disciplines working in the Health Centre and, experimentally for six months, a patient representative. The more formal "duties" of the Health Centre are dealt with through the Health Centre Management Committee to which the liaison committee reports.

30. The policy for administering the health centres has evolved over the past 3 years and for the future the intention is that there should be complete integration between the health centres and the hospitals in terms of having one administrator. It has been agreed that the health centres which are at present directly administered from the community health headquarters will at an appropriate time come under the administrative control of the appropriate hospital administrator. As far as possible during the planning stage we encourage the general practitioners to share telephones and

reception services and also to regard the manager as the person able to undertake the organisation of the health centre and to leave them free to undertake their clinical duties. On the whole this has been successful, but in one instance, where 2 practices were concerned, they have insisted on separate telephone and reception systems, and separation of the community and general practitioner side. We also try wherever possible to use the health centre as the distribution point for community items such as incontinence pads and medical loan equipment. Also the local community are encouraged to make the fullest possible use of the premises for health education in the widest possible sense, even where the functions or activities are not directly organised by Area Health Authority staff. I would counsel evolution rather than revolution in the integration of health centres into the district administration.

31. Essential to have full and frank discussion between all users prior to opening and determine areas of work/responsibility before making financial arrangements between Authority and GPs.

32. a) No particular difficulties
b) No particular successes in view of (a) above but smooth running may well be due to emphasis on communication being a vital ingredient and the need for all disciplines to work for the success of the whole.

33. Operational policies for the new health centre due to open in November 1977, a copy of which is attached, may be helpful. This is the first health centre to be wholly completed in the District since reorganisation, the organisation of which, and the related operational policies whilst designed to meet the particular needs of this health centre will serve to provide the basis for similar policies in other health centres and clinics.

34. Difficulty of getting GPs to understand the ramification of the N.H.S. particularly when changes or alterations are required and when certain costs have to be met. There are often problems as to who should pay.

35. Management In a developing community our experience is that there is a need for a manager to be permanently based at the centre in order to maintain continuity and monitor the growth of services and identify the needs of the community served.

36. There are difficulties in obtaining a sense of unity amongst the various disciplines working in a health centre, although a great deal is achieved if the administrator has sufficient drive and enthusiasm.

37. One difficulty relates to finance. There is a jungle of relationships: G.P. - F.P.C. - Area Treasurer - D.M.T. which the doctors find very confusing, (and so do we)!

38. School health records in H.C. - aid to Health Visitors.

39. Switchboard for GPs should always be kept totally separate from rest of services (no conflict over telephone bills).
Keep GP reception staff separate from other health service reception staff (this includes typing).

40. Apart from the overall problems of encouraging a harmonisation of the activities of professionals operating in health centres, one of the most disturbing difficulties from an administrative point of view has been in absorbing staff formerly employed directly by GPs in their own surgeries and who subsequently are completely disorientated by the different environment in which they work. Established loyalty to an individual GP or group practice and a lack of understanding of concepts of health centres can create havoc with one's attempts to integrate administrative support services. The answer would appear to be absolute authority on the issue of the selection of staff to rest with an experienced administrator when commissioning a new health centre or the provision of structured courses for receptionists when entering health centre employment for the first time.

41. No particular difficulties except in the initial 'settling-in' period when GPs had to adapt from having their own personal receptionists, practice nurses, etc. to a shared usage rota system.

42. 1. There is a good team approach within the practices and good communication with other users within the Centre.

2. The success of the Centre is largely due to the enthusiastic support of most Centre users who are keen to see the team approach to primary health care really work. Although the two GP practices operate differently, they both enthusiastically support the Centre. Their enthusiasm has "rubbed off" on other users.

3. The GPs were deeply involved at the Centre's planning stage.

4. The GPs express confidence in the existing administration and welcome their support.

5. The large number of visitors who are referred to the Centre help to maintain high staff morale and an awareness of the need to maintain high standards.

43. Administrative trainees on six-month attachments fill the post of Health Centre Administrator and this has proved to be extremely good experience for them. However, it is appreciated that this is not a wholly satisfactory situation from the Health Centre's point of view and consequently the position is being kept under review. The Health Centre's complaint is firstly that every six months they have to adjust to a new Administrator and this complaint is accepted as valid; secondly, the Centre feels aggrieved that they do not have a full-time Administrator. This complaint is not accepted as there is insufficient work to occupy a full-time administrator.

44. The appointment of the Administrator, well in advance of the opening of the new health centre, proved invaluable.

45. With some years experience of three fully functional health centres it is evident that such establishments rapidly become an effective focus for Community Health functions allowing for close co-ordination between preventive services, General Medical services and domiciliary services (i.e. Centre based Home Nurses and Domiciliary Midwives). There is a particular difficulty which should be avoided, however. Individual services are likely to expand and new services arise and in making provision for these eventualities care must be taken to have effective allocation of the Health Care Clinical accommodation.

Diversification of services can reach a level at which conflicting requirements of different services cannot be properly provided for due to the finite nature of accommodation within the centre.

46. It is often difficult to decide where problems are created more by personality/status clashes than administrative policies, particularly where strong individual personalities are clashed daily in a small building.

We generally already conform to the suggestions contained in the circular on health centre licences and allied matters.

We feel, strongly, that insufficient attention has been given by planners to layouts and rigid adherence to costs limits often cause immense problems for the users.

Sound-proofing is a neglected area and can be embarrassing.

We encourage staff to use the Common rooms for a morning 'cuppa' and lunches but it takes a strong personality to break down the separate box syndrome.

We have an open door policy and encourage the public to use the centres as information points for other services. We also encourage use for multi-disciplinary meetings.

In our newest centre - opening later this year - we hope to encourage regular use of a suite by social workers.

47. The structural design of the reception booths are particularly successful as it affords a degree of privacy for the patient which is lacking in many centres.

48. Difficulties
a) Lack of a House Committee
b) GPs not all in group practice
c) GPs employ own receptionists and secretarial staff since moving into the Centre in 1971
d) A jointly employed Administrative Officer AP III LA scale was appointed at GPs' request soon after opening but was not a success owing to the emergence of divided loyalties which served to undermine the administrator's authority. Post vacated within 2 years, not filled since then.

Successes: Group attachment of nursing staff.

49. It is undesirable for the H.C. Administrator to have his salary partially paid by the GPs and to act as practice manager. This leads to conflicting loyalties and makes it difficult to combine his duties. For similar reason it is desirable to employ all staff in the H.C. and to merely provide a service to the GPs just as hospital staff provide a service to consultants.

50. 1. The view in this district supports the employment of a full-time administrator responsible for one health centre and based in that health centre. It is felt that it would be difficult to achieve as good results with any other arrangement.

2. No particular administrative difficulties have been experienced with health centres in this district.

51. 1. Difficulties were being experienced at one health centre with unauthorised car parking - i.e. not patients nor staff using the Centre car park. For persistent offenders who could be identified, the help of the Region's legal department was enlisted and letters threatening court injunctions have solved the problem - but the casual user remains a problem.

2. Messages for Health Visitors and District Nurses. All messages received at the switchboard are recorded in a separate book for each discipline and a routine has been established where each D.N. and H.V. inspects the appropriate book and initials messages requiring her action.

52. We are firmly convinced that there must be a designated officer with administrative responsibility on site, whose responsibility is to co-ordinate the activities of the whole Centre, as well as performing other duties.

At the time of re-organisation this Health District took over two Centres from different Local Authorities. One had adopted this policy, the other preferring a senior receptionist with other matters being dealt with by a peripatetic administrator. We have been forced to continue these different arrangements. Our experience is, that this latter arrangement is cumbersome and results in a lack of leadership, direction and co-ordination at local level.

53. We have had difficulties over the employment by the Health District of a receptionist who works solely for the GP - the practitioners feel they have to some extent lost control of their staff, and the staff have slightly divided loyalties. The GPs feel they have lost control of the cost of such staff.

54. In this Centre the Administrator is also employed by the General Practitioners to administer the medical practices and satisfactorily co-ordinates the activities of all departments, establishing a closer link between the General Practitioners and all other sections of the services in the District.

55. Our policy is to use the Centre Management Committee to resolve problems and review services. This has enabled us to arrive at harmonious decisions about such things as periodic adjustment of Health Centre costs apportionment and proposals for enlarging the Health Centres.

56. At the Jenner Health Centre there are regular meetings of all Centre staff and GPs. Minor problems are sorted out at these meetings and those it is not possible to solve at this level are referred to the House Committee.

57. The accountability of administrative staff is often a difficulty where they are paid by the GPs and partly reimbursed by the authority. In some of the smaller Health Centres, because it has not been practical to nominate one individual, the tasks of liaising with functional officers sometimes involves two persons, one involved the GPs and me by the authority, as the accommodation at the older health centres often divides the services into virtually two separate units within the building.

58. Difficulties arise from demand for increase in number of surgeries for GPs and such accommodation is available only on an ad hoc basis.

Integrated working of GPs and community services is operating well.

59. Health Centre Administrators attend on a regular basis at District Managers meetings and also with other centre administrators for community services regular meetings.

Either of these meetings are essential if health centre administrators are to be kept informed of events and policies and given the opportunity of comparing work patterns and the solutions to day to day problems. In small health centres it is not economic to have an Administrator always on the premises but communication then becomes even more important.

60. There are difficulties in employing a general practitioner's receptionist or secretary as part-time administrator. We have two such in our district, paid by the general practitioners and part of the salary reimbursed by the district to the general practitioner. The administrator may at times be too heavily involved with practice work to turn her attention to health centre matters, may not appreciate the problems of the community staff, may shrug off problems and be biased towards the general practitioners. It is difficult to winkle them out for training or courses.

The one centre where the administrator is on the district payroll appears to run much more smoothly and happily.

In the two other centres, there is no administrator in charge and no real feeling of cohesion between general practitioners and community staff.

61. Each health centre (and health clinic) must be controlled with a full time clinic clerk to enable the community health services being fully supported and the local administration covered at all times.

62. Difficulties are experienced in view of the fact that at most of the centres/clinics, part-time clinic clerks only are employed. This obviously presents problems with regard to security arrangements delivery of supplies, etc. which results in nurses/health visitors being involved.

63. The community services administrator is based in an office at sector headquarters (in the district general hospital), close to the offices of the sector administrator and the divisional nursing officer (community). This arrangement facilitates communication between us and has resulted in a few improvements in services which help to integrate the health centres into this health district, (a) a specimen collecting service from the health centres to the pathology laboratory on most days of the week, (b) a supply of linen from the hospital laundry for district nurses based at one health centre to take to the homes of incontinent patients, (c) pooled use of hospital and community residential properties. Implementation of these and other district administrative policies might have been harder to accomplish if administration was decentralised to the extent of having an administrator based in one of the health centres or having a separate sector administrator for the community only able to call on hospital functional services indirectly.

64. We have never found it necessary to employ a full time administrator at each health centre. The practice of employing a 'middle manager' to look after several health centres has made it easier to integrate the community services with the hospital services on a geographical basis, through the sector administrators and has much to comment it.

Thus in one sector the community services administrator is responsible for two hospitals plus two health centres, whilst the C.S.A. in the other sector has oversight of four health centres - each being in turn responsible to his sector administrator who has oversight of all services.

65. Care in choice of personality of health centre manager - which post is essential.

Opportunity for para-medical or other staff to be co-opted on to, or to attend specific house committee.

Progress towards primary health care records, kept in health centre, available to all the team and not unique property of general practitioner, maintaining necessary standards of confidentiality. Health centre to include community as well as general practitioner functions and be prepared to extend facilities for out-patients.

66. A significant problem with the administration of health centres is that of the sharing concept. There is a tendency for the centres to split into two parts, (a) the general practitioner's surgery(s) (b) Health Authority services. A major cause of this problem is the rents charged to general practitioners for their use of parts of the centre. This leads to a lack of willingness (perhaps on both sides) to share properly the resources of the centres.

67. The main thing is not to be doctrinaire about the management and administrative arrangements or general practitioners get alarmed and think someone is trying to take them over. Ideally it might be better to have more administrative control but not if it meant sacrificing good relationships with general practitioners.

68. There are three health centres within the district, two have been opened since 1.4.74. In the main the commissioning of these centres has been successful. Design in use has produced very few problems, except for the hoary problem of adequate car parking space at certain peak periods when general practitioners patients and community health patients attend at the same time. Dependent on the locality and the services which were previously provided, there can be an excessive community demand on the use of the building for family planning, mothers clubs, all of which take place in the evening and thus incur heavy running costs with heating, lighting, etc.

69. I think our health centres are run in a somewhat pedestrian fashion but one cannot expect them to be turbulent swinging establishments. I would like to evolve some way of involving the staff in other health activities which is compatible with peak and trough life in the health centre.

Working in a health centre is a very easy life and the NHS does not really get value for money from the staff.

70. At all stages of planning of centres and extensions and during commissioning, it is important that all parties are members of the team and there should be full participation and communication at all times.

The person appointed as administrator although fully a district responsibility must be acceptable to all users of the centre. There must be complete understanding and communications at all times between the administrator and his/her immediate supervisor.

71. Consideration is at present being given to making the community services administrator responsible for health centres as so much of the work is community orientated.

Sector administrators are responsible for making available the functional services to health centres, e.g. supplies, engineering.

The community services administrator would, as things stand at present have to approach sector administrators for the use of functional services. There are a number of possible answers but the problem is compounded because of the geography of this rural district.

72. At the moment health centres fall into one of three geographical sectors, because of their physical location this means that one sector in particular has a large number of health centres. As the health centre administrators are responsible to three separate people, creation of uniform district policies is difficult but relationships between health centre administrators and sector administrators is more positive.

73. It is felt that the health centres in this district are at the moment too small to justify the establishment of large multi-disciplinary House Committees. The system operative at the health centre is preferred where all the general practitioners and the health centre administrator meet regularly and other persons come by invitation on occasions when their presence is considered appropriate for the item(s) on the agenda for discussion.

74. There has been reluctance on the part of some of the community health staff to accept the fact that re-organisation has happened. This attitude was perhaps due to an understandable suspicion of a new employer who has different working arrangements and policies. The main 'opposition' was to the managerial structure as we did not feel it necessary to create a separate tier for community health services. The general administration is linked through the sector administrator responsible for the hospital acute services, and the health visitors and district nurses are accountable to the divisional

nursing officer who also has responsibility for the hospital acute services. The situation has, however, improved steadily over the past two years, helped by regular meetings at sector level where problems and suggestions for improving the service can be openly discussed.

75. There is only one health centre in this health district and this is not a true health centre in that a very large number of general practitioners use the centre more in the form of a branch surgery. This has led to difficulties in regard to agreeing realistic charges.

76. 1. The concept of sector administrator running health centre leaving one with an advisory/training function has worked (I still deal with all planning/commissioning of centres).

2. Finance causes problems, more so when there is a fully integrated centre. It is relatively easy to settle financial arrangements when general practitioners remain almost isolated, the more centre adopts a team approach the greater the financial complications. So far we have thought the benefits to the patient outweigh the admin. complications.

3. The advent of health centres has left clinic clerks fearful of their status - joint meeting and training has helped greatly.

4. Health centre administrators have been encouraged to maintain links with the F.P.C. and with the Post Graduate Medical Centre, in particular to participate in functions/courses arranged for general practice. It is felt that this has helped to avoid friction between general practitioners and their staff working outside health centre and those in centres.

77. The A.H.A. decided to retain health centre management as a function of the area office and AMO in order to avoid differing district policies on health centre provision in the area and in particular to avoid differing legal agreements.

Successes

The success of the generally very good working relationships we enjoy with the general practitioners in our health centres is due mainly to -

1. Very close consultation with the general practitioners concerned at all stages of the planning of the building and of furnishing arrangements, and allowing for personal preference whenever possible, and

2. The establishment, prior to the building being brought into use, where possible, of a good rapport between the area's officers and the general practitioners and their staff, which tends to set the pattern of future relationships.

3. Design has been good: two health centres have been included in various editions of D.H.S.S. design guide, and one centre won a Civic Trust award - jointly first in the country to do so.

Difficulties

In health centres which accommodate more than one Practice, experience indicates that it is most important that, again prior to the building being brought into use, that is is agreed with all the general practitioners concerned that one named person should be responsible for the administration of the building as a whole. Otherwise difficulties can arise as to the need to carry out, for example, certain redecorations, etc. and the apportionment of the resultant costs.

78. 1. Problems with area based services not meshing in with district needs.

2. Information re. performance is not readily available.

3. The district has a well developed functional budgeting system and the S.A. holds the majority of 'community budgets. This enhances his ability to manage within a defined area.

79. District had made considerable progress in implementing a financial agreement, pending publication of long-awaited national licence agreement, applicable to all four existing centres. Existing arrangements will be carried forward to licence agreements. We had hoped, with the opening of two new centres thatthe opportunity could be taken to have common reception/switchboard facilities for General Practitioner/Community Health Service patients. Unfortunately, the general practitioners were opposed to this concept and separate arrangements have resulted.

80. 1. Employment of receptionist staff by general practitioners leads to difficulties especially at a health centre where a number of the receptionists of the different practices share one room and are responsible for the switchboard.

2. Difficulties encountered with arrangements whereby general practitioners are charged a proportion of the running costs leading to the situation whereby the area health authority are unable to upgrade their exclusive portion of the health centre without agreement of the general practitioners.

81. Our experience indicates that unless general practitioners are involved in the initial discussions and planning of the health centre, there is less likelihood of the centre operating successfully. In the initial stages, it is necessary to ensure that there are no failures in the services being provided to the centre and once the systems are running satisfactorily, it has been found that the general practitioners do not relish having contact with non medical AHA representatives unless there is a specific problem to solve, therefore the minimal amount of formal contact is essential but must be compensated for by the development of personal relationships.

82. Community administrator only in post since Christmas 1976, therefore administration policies still very much undecided as yet.

83. The health centre supervisor having supervisory control of both clerks who work in community service clinic activities and general practitioner receptionists works well.

It is the experience of this district that such a post is of the greatest benefit to the Authority and General practitioners.

84. Experience in this district suggests that general practitioners employ their own practice manager.

Care of the building etc. can be dealt with by suitable caretaker and community clerical needs are met by clerks from this authority.

85. Providing district not identified. We have difficulty in our receptionist/patient relationships. Receptionist is inevitably supported by doctor, but administrators have reservations that there is no smoke without fire.

86. The recent development in this district of two health centres simultaneously has nevertheless resulted in two very different organisations both in terms of scale and operational policies. As will be seen from Questionnaire B, there are differences in the

employment of support staff as between the Authority and the General Practitioners and the attachment of community staff is more integrated in the one than the other. It may be that to some General Practitioners the opportunity to practise from a health centre is simply seen as a move of accommodation which may be prompted by a lease falling in or a surgery being in a clearance area.

It is self-evident that the more successful health centre will be that where there is a whole-hearted acceptance of the concept of the primary health care team, for which the health centre provides a focus. In the absence of such integration, it may be that the way forward is to develop non-medical centres as the basis for community support care, with the addition at the appropriate time of general practitioner premises.

87. Successes

Listed below are points made by the senior clerk at the centre, supported by the community health services administrator and final observations of district administrator.

(a) Early foresight on the part of the general practitioners and administration in establishing a health centre bank account well in advance of opening, to cover initial expenses, ie. printing, advertising, removal costs etc.

(b) Early decision regarding division of general practitioner health centre expenses, i.e. by equal division or on capitation figures.

(c) Area Health Authority administration staff being appointed well in advance of the opening to enable supervision of move in of furniture and equipment for both general practitioners and area health authority. In particular, supervision of general practitioner medical records transfer to the health centres.

(d) Colour indication scheme to facilitate transfer of medical records from the various individual practices to the health centres.

Difficulties

1. The general practitioner reception staff should be employed by the area health authority direct, upon entering the health centre. However, if this cannot be agreed by the general practitioners then this staff should be placed on a recognised pay scale, comparable with Whitley on entry.

2. Ideally, the reception staff should be interchangeable between the general practitioners, no receptionist being responsible for one general practitioner at all times. This would be advantageous for cover for holidays, sickness, etc. particularly in view of the fact that most of this staff are employed only part time.

88. Financial arrangements require early determination - Essential to apportion appropriate costs for General and any accommodation made available to Social Services.

89. In one health centre. Should H.C. clinical room be used for patients not with general practitioner practice - agreed to use for them e.g. patients coming to have stitches out rather than travel to hospital.

90. Would claim some success in the area of the former County Borough, i.e. Major and satellite health centres with day to day control exercised through general administrative assistants or higher clerical officers who are accountable to sector administrator and his senio administrative assistants. Situation in the --- Local Government Districts has improved since 1974 with a general administrative assistant in one major health centre and higher clerical officers in smaller satellite-type health centres. Liaison with general practitioners is good although the 'machinery', i.e. House or Health Centre Committees, is currently under-used. Steps are to be taken to remind Health Authority staff and general practitioners of the need to keep this invaluable means of communication alive.

Considerable success has been achieved in major health centres by setting up "Triad' Teams, comprising:- Senior Clinical Medical Officer, Senior Nursing Officer and Administrative Assistant. These teams meet as the need arises to discuss day to day problems. If difficulties are encountered by the Triads, the matter is referred to the Central Office Triad, (i.e. District Community Physician, Divisional Nursing Officer (Community) and Sector Administrator (Community). It is generally felt that, with particular reference to the major health centres, the general practitioners tend to be so involved and pre-occupied in their professional duties that the original concept of frequent liaison with the various disciplines of the Community Health Services is not as effective as 'planned' prior to the building of these Health Centres in this Health District.

TABLES

Note on percentages in the tables

Many of the tables are rather complicated and we have on a number of occasions not included percentages as these will make the presentation even more complex. (The information needed to calculate such percentages is of course there in the tables). Where we have calculated percentages these are usually calculated to the nearest whole number except in a few cases where the denominators in question were suitably large and their computation to this degree of accuracy seemed useful in terms of the subject matter.

TABLE 1

Response by health districts and single district areas

Type of Response	District		Single District Area		All	
	No.	%	No.	%	No.	%
Responded	162	95	31	91	193	94
Did not respond	9	5	3	9	12*	6
Total	171	100	34	100	205	100

* 5 did not reply

6 refused in writing

1 sent an incomplete response

TABLE 2

Response from Districts and Single District Areas for N.H.S. regions.

Region.	No. of Health Districts			No. of Single District areas.			Total of Health Districts and Single District areas.		
	Responding	Not responding	Total	Responding	Not responding	Total	Responding	Not responding	Total
Northern	9	1	10	5	1	6	14	2	16
Yorks	15	1	16	1	-	1	16	1	17
Trent	13	2	15	3	-	3	16	2	18
E. Anglia	7	-	7	-	-	-	7	-	7
N. W. Thames	16	1	17	-	1	1	16	2	18
N. E. Thames	17	-	17	-	-	-	17	-	17
S. E. Thames	15	-	15	1	-	1	16	-	16
S. W. Thames	12	-	12	2	-	2	14	-	14
Wessex	9	-	9	1	-	1	10	-	10
Oxford	4	2*	6	1	-	1	5	2	7
South Western	12	-	12	1	-	1	13	-	13
West Midlands	13	2	15	7	-	7	20	2	22
Mersey	11	-	11	1	-	1	12	-	12
North Western	9	-	9	8	1	9	17	1	18
	162	9	171	31	3	34	193	12	205

*Includes one health district which responded to questionnaires of type B but not to questionnaire A.

TABLE 3

Response by estimated number of health centres*

Type of Response	In Districts		In Single District Areas		All centres	
	No	%	No	%	No	%
Responded	535	92.9	175	92.6	710	92.8
Estimated missing	41	7.1	14	7.4	55	7.2
Total	576	100	189	100	765	100

* Estimated by counting the number of health centres listed in the 1978 Health and Social Services Yearbook for health districts and single district areas who did not respond.

TABLE 4

No. of Health Centres in Districts and Single District Areas responding and and not responding for N.H.S. regions.

Region	No. of Health Centres in Health Districts and Single District areas		
	Responding	Not responding (estimated no. of Health Centres)	Total (estimated)
Northern	50	10	60
Yorkshire	67	7	74
Trent	77	21	98
East Anglia	25	-	25
N. W. Thames	30	5	35
N. E. Thames	38	-	38
S. E. Thames	17	-	17
S. W. Thames	47	-	47
Wessex	31	-	31
Oxford	47	4	51
South Western	94	-	94
West Midlands	74	3	77
Mersey	37	-	37
North Western	76	5	81
	710	55	765

* Estimated by counting the number of health centres listed in the 1978 Health and Social Services Yearbook for health districts and single district areas who did not respond.

TABLE 5

Titles of officers completing Questionnaire A about policy of HD/SDA on administration of health centres.

Title	No.	%
Sector Administrator	39	23
District/Area Administrator	27	16
Community Services Administrator	24	14
General Administrator	18	11
Assistant District Administrator	10	6
Operational Services Manager	9	5
Senior Administrative Assistant	9	5
Principal Administrative Assistant	6	4
Support Services Manager	4	2
Administrative Assistant - unspecified	4	2
Planning Officer	3	2
Unit Administrator	2	1
F.P.C. Administrator	2	1
Other	4	2
No answer	9	5
TOTAL	170	100

TABLE 6

Number of centres in HD/SDA by type of administrative system

No. of centres in HD/SDA	System type*				
	Geographical	Community	Pragmatic	Mixed	Total
1, 2	19	39	5	1	64
3, 4	20	26	3	1	50
5, 6, 7	11	21	-	3	35
8 or more	5	11	2	3	21
Total	55	97	10	8	170

* See page 4

TABLE 7

Types of officers in the different types of 'system' in HD/SDAs for managing health centres (see page 5)

Title of Officer	ONE SYSTEM															TWO SYSTEMS									Total types of officer mentioned (All systems)	
	Type of system															First system				Second system						
																Type of system				Type of system						
	Geographical						Community						Pragmatic			Geographical	Community			Geographical	Community			Pragmatic		
	One person *	Two persons *		Three persons *			One person *	Two persons *		Three persons *			One person *	Two persons *		One person *	One person *	Two * persons		One person *	One person *	Two * persons		One person *	No.	%
		1st person	2nd person	1st person	2nd person	3rd person		1st person	2nd person	1st person	2nd person	3rd person		1st person	2nd person			1st person	2nd person			1st person	2nd person			
Sector Administrator	28	20	1	-	-	1	41	6	3	1	1	-	1	1	1	5	1	1	-	1	-	1	-	1	115	51
Unit Administrator	2	-	5	-	-	-	-	-	2	-	-	-	-	1	-	-	-	-	-	1	-	-	-	1	12	5
Community Services Administrator	-	-	7	1	-	-	33	5	1	1	-	-	-	-	-	-	-	-	1	-	1	-	1	-	51	23
Senior Administrative Assistant	-	-	1	-	1	-	3	1	2	-	1	-	2	-	-	-	-	-	-	-	-	-	-	-	11	5
Principal Administrative Assistant	-	-	-	-	-	-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	2	1
General Administrator	-	-	1	-	-	-	-	1	1	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	5	2
Assistant District Administrator	2	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	3	1
Operational Services Manager	-	-	-	-	-	-	-	-	1	-	-	-	1	-	1	-	-	-	-	-	-	-	-	1	4	2
Divisional Manager	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	3	1
F.P.C. Administrator	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
Deputy Community Services Administrator	-	-	1	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	1
DCP/AMO	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	1	2	1
Support Services Manager	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	1
General Administrative Assistant	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1	-
Assistant Sector Administrator	-	-	2	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4	2
Health Centre Administrator	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
Planning Officer	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
Administrative Assistant (unspecified)	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	2	1
Other	-	-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	1
Total	33	21	21	1	1	1	80	15	15	2	2	2	7	3	3	5	2	1	1	2	1	1	1	4	225	100

* No of persons in the system (geographical, community or pragmatic) mentioned by respondents

TABLE 8

Preferred arrangements* for day-to-day administration of health centres by health districts and single district areas

(See Chart on p. 54)

Employment category	Health District No.	%	Single District Area No.	%	All No.	%
A	61	43	6	21	67	39
B	25	18	2	7	27	16
C	29	21	7	24	36	21
D	33	23	7	24	40	24
E	23	16	2	7	25	15
F	48	34	12	41	60	35
G	14	10	3	10	17	10
Other	2	1	1	3	3	2
Total no. of HD/SDAs on which % is based	141	100	29	100	170	100

* N.B. Many HD/SDAs gave more than one preference (see Table 9)

TABLE 9

Arrangements for day-to-day administration of health centres preferred by Health Districts and Single District Areas.

Whether Health Districts or Single District Areas	Preferred administrative arrangements *																	
	One or more of A B C only		D with or without one or more of A B C only		F only		E only or E with F only		G only or together with any other category		One or more of A B C or D together with F or with E and F		One or more of A B C D with E only		Other only		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Health Districts	60	43	13	9	16	11	8	6	14	10	22	16	7	5	1	1	141	100
Single District Areas	11	38	2	7	6	21	2	7	4	14	3	10	-	-	1	3	29	100
Total	71	42	15	9	22	13	10	6	18	11	25	15	7	4	2	1	170	100

* These combinations of employment categories are used since respondents often indicated several such categories as being "preferred".
See also Chart on p. 54 for definition of employment categories.

TABLE 10

Arrangements for day-to-day administration of health centres preferred by HD/SDAs by actual employment categories of those responsible for the day-to-day administration of health centres for one person centres.

Actual employment categories	Preferred administrative arrangements. *								
	One or more of A B C only	D with or without one or more of A B C only	F only	E only or E with F only	G only or together with any other category	One or more of A B C or D together with F or with E and F	One or more of A B C D with E only	Other only	Total
A	104	20	7	3	22	8	5	12	181
B	18	-	-	-	-	-	8	-	26
C	50	13	2	1	8	6	-	3	83
D	28	17	4	1	2	18	2	3	75
E	-	-	13	18	1	2	1	-	35
F	8	-	40	12	8	16	-	-	84
G, H	4	2	7	1	17	4	-	-	35
I	1	-	-	-	3	6	-	-	10
TOTAL	213	52	73	36	61	60	16	18	529**
No. of HD/SDAs expressing preference for indicated administrative arrangements.	65	14	18	6	15	17	7	2	144

* These combinations of employment categories are used since respondents often indicated several such categories as being "preferred". See also Chart on p. 54 for definition of employment categories.

** Excludes nine centres where HD/SDA did not complete a questionnaire A.

TABLE 11

Arrangements for day-to-day administration of health centres preferred by HD/SDAs by actual employment categories of those responsible for the day-to-day administration of health centres for two person centres.

Actual combinations of employment categories	Preferred administrative arrangements *								
	One or more of A B C only	D with or without one or more of A B C only	F only	E only or E with F only	G only or together with any other category	One or more of A B C or D together with F or with E and F	One or more of A B C D with E only	Other only	Total
1	15	1	-	-	-	10	7	-	33
2	3	-	-	-	1	4	-	-	8
3	2	-	9	-	-	5	1	1	18
4	-	-	-	-	1	-	-	-	1
5	3	1	4	4	-	17	2	-	31
6	-	-	11	1	-	4	-	-	16
7	-	-	-	-	1	1	-	-	2
8	-	-	3	-	-	1	1	-	5
9	3	1	4	1	2	6	1	-	18
TOTAL	26	3	31	6	5	48	12	1	132
No. of HD/SDAs expressing preference for indicated administrative arrangements.	16	2	10	5	4	15	3	1	56

Definition of actual combinations of employment categories.

1. Two administrators each of type A B C or D
2. Two administrators, one of type G or H with one of type A B C or D
3. Two administrators, one of type E with one of type A B C or D
4. Two administrators, one of type E and the other of type E or F
5. Two administrators, one of type F with one of type A B C or D
6. Two administrators both of type F
7. Two administrators both of type G or H
8. Two administrators one of type G or H with one of type E or F
9. Two administrators, any other combination
   This category includes the following combinations:-
   An administrator of type A B C or D with one of unspecified type (6 cases)
   An administrator of type E with one of unspecified type (one case)
   An administrator of type F with one of unspecified type (one case)
   Two administrators both of unspecified type (one case)
   One administrator type A B C or D with an 'other'(type I)administrator (5 cases)
   One administrator of type F together with one 'other'(type I)(4 cases)

* These combinations of employment categories are used since respondents often indicated several such categories as being "preferred".
See also Chart on p. 54 for definition of employment categories.

TABLE 12

Arrangements for day-to-day administration of health centres preferred by HD/SDAs by actual employment categories of those responsible for the day-to-day administration of health centres for three person centres

Actual combinations of employment categories	Preferred administrative arrangements *								
	One or more of A B C only	D with or without one or more of A B C only	F only	E only or E with F only	G only or together with any other category	One or more of A B C or D together with F or with E and F	One or more of A B C D with E only	Other only	Total
1	1	4	1	-	1	-	3	-	10
2	-	-	2	-	5	1	1	-	9
3	1	-	4	3	1	-	-	-	9
4	1	-	3	-	-	-	-	1	5
TOTAL	3	4	10	3	7	1	4	1	33
No. of HD/SDAs expressing preference for indicated administrative arrangements.	2	1	4	2	4	1	2	1	17

Definition of actual combinations of employment categories

1. Three administrators each of type A B C or D
2. Three administrators, at least one of each of type G or H.
3. Three administrators, all of type A B C D E or F including at least one of type A B C or D and at least one of type E or F.
4. Any other combination of three administrators. In fact the following combinations are included in this category:
   Two administrators of type A B C or D with one administrator of 'other' type(I)(3 cases)
   One administrator of type A B C or D with one administrator of type E and one of 'other' type(I)(2 cases)

* These combinations of employment categories are used since respondents often indicated several such categories as being "preferred".
See also Chart on p. 54 for definition of employment categories.

TABLE 13

Types of background factors mentioned as suitable for staff employed by the health authority in a health centre to carry out day-to-day administration.

Factor	No.of times mentioned
General background :-	
Clerical	45
Secretarial	36
Administrative	33
Supervisory	13
Nursing	1
Experience of health services :-	
Health service experience unspecified	60
Community health experience	15
General practice experience	15
Hospital experience	8
Local authority health service experience	7
Armed forces health service experience	6
Having or studying for H.S.A. qualifications	24
Personal qualities :-	
Organising ability	23
Tact, charm	12

These results are based on answers given by 98 HDs/SDAs. 21 HDs/SDAs did not answer this question and 51 did not have health centre based administrative staff so that the question was not applicable to them.

TABLE 14

Types of training which it is the policy of the HD/SDA to give to staff employed in a health centre to carry out day-to-day administration.

Type of training mentioned	For newly appointed staff	For staff in post
None	18	23
Induction course	38	-
First line management	4	14
Middle management	5	12
Other management courses	4	19
Visits to other health centres	42	-
Time with F.P.C.	1	-
Trade Union course	1	1
Association of Health Centre and Group Practice Administrators courses	-	6
Other training	19	45

These results are based on answers given by 98 HDs/SDAs. 21 HDs/SDAs did not answer the question and 51 did not have health centre based administrative staff so that the questionnaire was not applicable to them.

TABLE 15

Types of training which it was the policy of the HD/SDA to give to those staff newly appointed to health centre administrator posts by salary grade(s) thought appropriate by HD/SDAs for staff undertaking the day-to-day administration of health centres

Types of training mentioned	Salary grade(s) thought appropriate										
	No answer	Clerical Officer and Higher Clerical Officer	Higher Clerical Officer	Higher Clerical Officer and General Administrative Assistant	Higher Clerical Officer and Senior Administrative Assistant	Higher Clerical Officer and Other	General Administrative Assistant	General Administrative Assistant and Senior Administrative Assistant	General Administrative Assistant and Other	Senior Administrative Assistant	Total
No answer	19	-	1	1	-	-	-	-	-	-	21
No training at all	-	-	2	7	-	1	5	2	-	1	18
Visits to other health centres only	-	3	4	7	-	-	7	-	-	-	21
Induction Course only	-	1	2	5	-	-	4	2	1	-	15
Middle Management Course only	-	-	-	-	-	-	1	-	-	-	1
Other Course only	-	-	1	4	1	-	2	1	-	-	9
Visits to health centres plus Induction Course	-	-	3	6	-	-	3	1	1	-	14
Visits to health centres plus First Line Management Course	-	-	-	2	-	-	-	-	-	-	2
Visits to health centres plus other Management Course	-	-	-	-	-	-	-	1	-	-	1
Visits to health centres plus other Course	-	-	-	2	-	-	2	-	-	-	4
Induction Course plus First Line Management Course	-	-	-	1	-	-	1	-	-	-	2
Induction Course plus Middle Management Course	-	-	-	-	-	-	2	-	-	-	2
Induction Course plus other Management Course	-	-	-	-	-	-	1	-	-	-	1
Induction Course plus other Course	-	-	1	1	1	-	1	-	-	-	4
Middle Management plus Trade Union Course	-	-	-	1	-	-	-	-	-	-	1
Middle Management plus other Course	-	-	-	-	-	-	1	-	-	-	1
Other Management plus other Courses	-	-	-	-	-	-	1	-	-	-	1
Time with Family Practitioner Committee plus other Management Course	-	-	-	-	-	-	-	-	-	1	1
TOTAL	19	4	14	37	2	1	31	7	2	2	119*

* 119 excludes 51 who did not have health centre based administrative staff.

TABLE 16

Types of training which it was the policy of the HD/SDA to give to staff already in health centre administrator posts by salary grade(s) thought appropriate by HD/SDAs for staff undertaking the day-to-day administration of health centres.

Types of training mentioned	Salary grade (s) thought appropriate										
	No answer	Clerical Officer and Higher Clerical Officer	Higher Clerical Officer	Higher Clerical Officer and General Administrative Assistant	Higher Clerical Officer and Senior Administrative Assistant	Higher Clerical Officer and other	General Administrative Assistant	General Administrative Assistant and Senior Administrative Assistant	General Administrative Assistant and Other	Senior Administrative Assistant	Total
Not applicable	-	-	-	-	-	-	-	1	-	-	1
No answer	19	-	-	1	-	-	1	-	-	-	21
No training at all	-	1	3	11	-	1	6	1	-	-	23
First Line Management Course only	-	-	2	2	1	-	-	-	-	-	5
Middle Management Course only	-	-	-	2	-	-	2	-	-	-	4
Other Management Course only	-	-	1	2	-	-	6	-	-	-	9
A.H.C.P.A.* Course only	-	-	-	-	-	-	-	-	-	-	-
Other Course only	-	1	5	12	-	-	9	3	2	1	33
First Line Management plus Middle Management Course	-	-	1	-	-	-	2	1	-	-	4
First Line Management plus other Management Course	-	1	1	-	-	-	-	-	-	-	2
First Line Management plus other Course	-	1	-	1	-	-	1	-	-	-	3
Middle Management plus A.H.C.P.A.* Course	-	-	-	1	-	-	-	-	-	-	1
Middle Management plus other Course	-	-	-	1	-	-	2	-	-	-	3
Other Management plus A.H.C.P.A.* Course	-	-	1	1	1	-	-	-	-	1	4
Other Management plus T.U.C. Courses	-	-	-	1	-	-	-	-	-	-	1
Other Management plus other Courses	-	-	-	-	-	-	2	1	-	-	3
A.H.C.P.A.* and other Course	-	-	-	1	-	-	-	-	-	-	1
Two 'other' types of course	-	-	-	1	-	-	-	-	-	-	1
TOTAL	19	4	14	37	2	1	31	7	2	2	119**

* A.H.C.P.A. - Association of Health Centre and Practice Administrators.

** 119 excludes 51 who did not have health centre based administrative staff

TABLE 17

Career structure thought appropriate for staff employed by the health district/S.D.A. to undertake day-to-day administration in a health centre, by the type of system for administering health centres in the district/S.D.A.

Career structure	Type of system in health district/S.D.A.							
	Geographical		Community		Pragmatic	Two systems	All	
	No.	%	No.	%	No.	No.	No.	%
None	2	5	8	12	1	-	11	9
Progress to larger centre or more than one centre	1	3	1	1	-	-	2	2
Community health services administration	9	23	18	26	-	2	29	24
Health services administration generally	12	30	25	37	1	2	40	34
Other	5	13	6	9	-	1	12	10
Has not applied in district/SDA	1	3	-	-	1	-	2	2
Not answered	10	25	10	15	1	2	23	19
Total	40	100	68	100	4	7	119*	100

* This excludes 51 health districts/SDAs who did not have health centre based administrative staff so that the question was not applicable to them. Of these 51, 15 had geographical systems, 29 community systems, 6 pragmatic and 1 had 2 systems

TABLE 18

Whether or not a career structure was envisaged for health centre administrators by the number of centres in the HD/SDA

No. of centres in HD/SDA	Career structure envisaged									
	Not * applicable	None	Progress to larger health centre	Community health service administration	Health service administration generally	Other	Has not applied in HD/SDA	Not answered	Total except "not applicable"	Total
1, 2	21	2	-	13	18	3	-	7	43	64
3, 4	14	4	-	6	11	7	2	6	36	50
5, 6, 7	11	2	2	7	6	2	-	5	24	35
8 or more	5	3	-	3	5	-	-	5	16	21
Total	51	11	2	29	40	12	2	23	119	170

* 51 of the 170 HD/SDAs did not have health centre based administrative staff so this question was not applicable to them

TABLE 19

Salary grades preferred by HD/SDAs for staff based in health centres for day-to-day administration.

Grade preferred	No.	%
General Administrative Assistant	77	50
Higher Clerical Officer	58	38
Senior Administrative Assistant	11	7
Clerical Officer	4	3
Other	3	2
Total	153*	100

* This total excludes 51 of the 170 HD/SDAs with health centres who do not have health centre based administrative staff to whom the original question was therefore not applicable.

The total also excludes 19 who did not answer the question. The total of 153 comprises 47 who mentioned one grade and 53 who mentioned two grades. There did not appear to be any order effect when two grades were mentioned.

TABLE 20

Preferences of HD/SDAs on who should pay the salaries of persons in health centres employed to undertake day-to-day administration

Preference on who pays salary	Health Districts No.	%	Single District Areas No.	%	All No.	%
HD/SDA pay all	41	41	10	50	51	43
G.P.s to contribute	43	43	2	10	45	38
Do not mind	4	4	1	5	5	4
No answer	11	11	7	35	18	15
Total	99	100	20	100	119*	100

*This total excludes 51 HD/SDAs who did not have health centre based administration staff so that the question was not applicable to them.

TABLE 21

Preference of HD/SDAs on who should employ General Practitioner reception staff in health centres

Preference on employment	Health Districts No.	%	Single District Areas No.	%	All No.	%
HD/SDA to employ	64	45	7	24	71	42
G.P.s to employ	56	40	15	52	71	42
Do not mind	21	15	7	24	28	16
Total	141	100	29	100	170	100

TABLE 22

Preference of HD/SDAs on who should employ reception staff by who employs reception staff in health centres.

Employer of reception staff in centres	Preference of HD/SDA							
	Authority to employ		G.Ps. to employ		Do not mind		All centres	
	No.	%	No.	%	No.	%	No.	%
G.P. employs	77	29	284	87	66	61	427	61
Authority employs	176	66	28	9	37	34	241	34
Varies between practices	12	5	7	2	5	5	24	3
No answer	1	-	6	2	1	-	8	1
All centres	266	100	325	100	109	100	700*	100

* This total excludes 10 centres where the policy of the HD/SDA on employing reception staff was not known.

TABLE 23

Views on the importance of having a health centre house committee by type of HD/SDA.

View on house committee	Health district No.	%	Single district area No.	%	All No.	%
Essential	31	22	11	38	42	25
Desirable	81	58	14	48	95	56
Not important	26	18	4	14	30	18
Undesirable	3	2	-	-	3	2
Total	141	100	29	100	170	100

TABLE 24

Views of HDs /SDAs on the importance of having health centre house committees, and existence of a house committee in their health centres

View on importance of house committee	Existence of house committee							
	Centres with committee		Centres without committee		No answer	Total	
	No.	%	No.	%		No.	%
Essential	129	38	44	12	-	173	24
Desirable	171	51	199	55	7	377	53
Not important	31	9	100	28	4	135	19
Undesirable	-	-	15	4	-	15	2
No answer	6	2	4	1	-	10	1
Total	337	100	362	100	11	710	100

TABLE 25

Preferred membership of health centre committees

HD/SDA view on Membership	Type of Member																	
	G.P. represent-ative		All		F.P.C. represent-ative		Nurse based in centre		Nursing Officer		Health Centre Administrator		An Administrative Officer		Receptionist representative		Consumer representative	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Essential	132	78	14	8	38	22	100	59	54	32	133	78	71	42	47	28	7	4
Desirable	12	7	42	25	34	20	30	18	59	35	11	6	41	24	32	19	25	15
Do not mind	5	3	39	23	54	32	17	10	32	19	-	-	33	19	36	21	47	28
Undesirable	4	2	48	28	27	16	7	4	11	6	6	4	12	7	38	22	71	42
Not answered *	17	10	27	16	17	10	16	9	14	8	20	12	13	8	17	10	20	12
Total	170	100	170	100	170	100	170	100	170	100	170	100	170	100	170	100	170	100

* Includes 10 HD/SDAs who did not answer this question at all, others did not answer all sections

TABLE 26

Title of administrative officer preferred, if stated, for membership of health centre house committee

Title of officer	No. of HD/SDAs mentioning	%
Sector administrator	51	45
Community Services Administrator	26	23
General Administrative Assistant	7	6
Unit Administrator	7	6
Senior Administrative Assistant	6	5
Principal Administrative Assistant	3	3
Sector and Unit Administrator	3	3
Assistant District Administrator	3	3
Other	8	7
Total	114*	100

* 56 of the 170 HD/SDAs did not nominate a specific officer

TABLE 27

Other persons mentioned as appropriate for membership of the health centre house committee.**

Person mentioned	No. of HD/SDAs mentioning
Dental Officer	44
D.C.P./A.M.O.	26
Chiropodist	22
Paramedical	16
Community medical officer	16
Social worker	10
General dentist	8
Speech therapist	8
Pharmacist	6
Works representative	6
Treasurer	4
Any providers of services in the centre	12
Ad hoc as necessary	7
Others	15*

* These comprise:-

Psychologist (2 mentioned)
Domestic staff representative (2 mentioned)
Engineer
Home help
Clinic clerk
D.M.T. Officers
District Functional Officers
Secretarial representative
A.H.A. representative
Domestic supervisor
Area Dental Officer
Supplies Officer
Consultant

** HD/SDA could mention more than one additional person

TABLE 28

Existence of a permanent or ad hoc health care planning team, wholly or substantially concerned with community/primary health care services for districts/SDAs, by the type of system for administering health centres in the district/SDA.

Community/Primary health services planning team	Type of system[3] in health district/SDA							
	Geographical		Community		Pragmatic	Two systems	All	
	No.	%	No.	%	No.	No.	No.	%
Yes	11	20	35	36	3	3	52	31
No.	38	69	48	49	7	4	97	57
Yes, within functional team [1]	2	4	7	7	-	-	9	5
No, only functional teams [2]	-	-	2	2	-	-	2	1
No answer	4	7	5	5	-	1	10	6
Total	55	100	97	100	10	8	170	100

1. Includes health districts/SDAs who had functional teams (e.g. for the elderly, for child health) which they considered covered primary care services.
2. Includes health districts/SDAs who had functional teams, which they considered were not substantially concerned with primary care services.
3. See page 4 for definition of system.

TABLE 29

Titles of officers completing Questionnaire B on individual health centres.

Title	No.	%
Sector Administrator	171	24.1
Community Services Administrator	98	13.8
Deputy Community Services Administrator	74	10.4
Health Centre Administrator	67	9.4
Principal Administrative Assistant	31	4.4
General Administrator	30	4.2
Assistant Sector Administrator	24	3.4
Unit Administrator	24	3.4
Higher Clerical Officer	21	3.0
District/Area Administrator	21	3.0
Administrator - unspecified	20	2.8
F.P.C. Administrator	17	2.4
Operational Services Manager	16	2.2
Assistant District Administrator	13	1.8
Clerk/secretary in health centre	13	1.8
Support services manager	10	1.4
General Administrative Assistant	8	1.1
Planning Officer	6	0.8
Divisional Administrator	3	0.4
Nursing Officer	2	0.3
Nurse/Health Visitor	2	0.3
General Practitioner	1	0.1
Other	4	0.6
Not answered	34	4.8
Total	710	100

TABLE 30

Year of opening of health centres in the survey according to respondents

Year opened	No. of centres in survey
1948 - 1959	18
1960 - 1965	21
1966	7
1967	21
1968	42
1969	44
1970	48
1971	81
1972	73
1973	87
1974	88
1975	66
1976	63
1977	51
Total	710

TABLE 31

Number of practices by total number of general practitioners in the health centre

No. of practices	Total number of general practitioners				
	1 - 4	5 - 8	9 - 12	13 or more	All
1	246	90	7	1	344
2	51	84	23	2	160
3	10	62	28	8	108
4	4	23	20	5	52
5 or more	0	17	12	12	41
Total	311	276	90	28	705*

* excludes 5 centres with no G.P. s

Average no. of doctors per centre (all doctors) = 5.6

Average no. of doctors per centre (using centre as main surgery) = 5.0

TABLE 32

Number of practices in health centre by total number of general practitioners working mainly in the centre

No. of practices in health centre	Number of G.Ps working mainly in health centres					
	None	1 - 4	5 - 8	9 - 12	13 or more	All
1	12	250	76	6	0	344
2	4	63	70	22	1	160
3	3	19	62	21	3	108
4	1	7	31	12	1	52
5 or more	4	1	18	11	7	41
Total	24	340	257	72	12	705*

* Excludes 5 with no G.Ps working there at all.

TABLE 33

Types of health service premises adjacent to health centres *

Type of premises	No. adjacent to health centre
Clinic	47
G.P. hospital	44
Acute hospital	18
Geriatric hospital	8
Maternity (not G.P.) Hospital	2
Other hospitals	6
Area H.Q.	8
C.H.C. premises	4
Ambulance station	6
Other premises	12

* May be more than one per health centre

TABLE 34

Numbers of health centres where consultant sessions of various kinds were held either in the centre itself or if not in adjacent premises

Type of Session	Held in health centre		Held in adjacent premises only	
	No.	%*	No.	%*
Audiology	18	2.5	0	0
Chest	5	0.7	2	0.3
Dermatology	1	0.1	1	0.1
Dietary/Diabetic	4	0.6	0	0
E.N.T.	28	3.9	3	0.4
General/Physical Medicine	18	2.5	4	0.6
General Surgery	19	2.7	6	0.8
Geriatrics	15	2.1	4	0.6
Gynaecology	21	3.0	7	1.0
Mentally Subnormal/ Handicapped	8	1.1	0	0
Obstetrics	8	1.1	4	0.6
Ophthalmology	21	3.0	2	0.3
Orthodontic	3	0.4	0	0
Orthopaedic	24	3.4	5	0.7
Paediatric	35	4.9	3	0.4
Psychiatry	74	10.4	5	0.7
Radiotherapy	4	0.6	1	0.1
Rheumatology	6	0.8	0	0
School Ophthalmology	43	6.1	3	0.4
Urology	1	0.1	1	0.1
Venereal Disease	1	0.1	0	0
"All specialties" written in	2	0.3	3	0.4
Other sessions mentioned	18	2.5	2	0.3

* percentages based on total of 710 centres in the survey

N.B. Consultant sessions were held in the centre itself or in adjacent premises in 24.4% of the 710 health centres in the survey

TABLE 35

Numbers of health centres where various services were provided, either in the centre itself, or if not in adjacent premises

Service provided	Held in health centre		Held in adjacent premises only	
	No.	%*	No.	%*
School dental	407	57.3	18	2.5
General dental	59	8.3	5	0.7
General ophthalmic	78	11.0	6	0.8
General pharmacy	29	4.1	11	1.5
Physiotherapy	119	16.8	29	4.1
Chiropody	574	80.8	15	2.1
Speech therapy	460	64.8	15	2.1
Child guidance	154	21.7	9	1.3
X-ray	20	2.8	21	3.0
Social work session	209	29.4	11	1.5

* percentage based on total of 710 health centres in the survey

TABLE 36

Existence of house committee in health centre by total number of general practitioners

Existence of house committee	Total number of general practitioners									
	1-4		5-8		9-12		13 or more		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Centre has house committee	113	36	147	53	59	66	17	61	336	48
No house committee	192	62	124	45	31	34	11	39	358	51
No answer	6	2	5	2	-	-	-	-	11	2
TOTAL	311	100	276	100	90	100	28	100	705*	100

* This total excludes 5 centres without any G.P. s

TOTAL 37

Existence of house committee in health centres by number of practices

Existence of house committee	Number of practices											
	1		2		3		4		5 or more		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Centre has house committee	119	35	89	56	65	60	35	67	28	68	336	48
No house committee	217	63	71	44	41	38	17	33	12	29	358	51
No answer	8	2	-	-	2	2	-	-	1	2	11	2
Total	344	100	160	100	108	100	52	100	41	100	705*	100

This total excludes 5 centres without any G.Ps

TABLE 38

Employer of reception staff by total number of general practitioners in the health centre

Employer of reception staff	Total number of general practitioners in health centre									
	1 - 4		5 - 8		9 - 12		13+		Total	
	No	%	No	%	No	%	No	%	No	%
G.Ps	187	60	176	64	53	59	11	39	427	61
Health authority	115	37	85	31	33	37	15	54	248	35
G.Ps and health authority share	2	1	1	-	-	-	-	-	3	-
Varies between practices	4	1	11	4	4	4	2	7	21	3
Total	311[1]	100	276[1]	100	90	100	28	100	705[2]	100

1 Totals include 3 no answers

2 Total excludes 5 health centres with no G.P s

TABLE 39

Employer of reception staff by number of practices in health centre

Employer of reception staff.	No. of practices in health centre											
	1		2		3		4		5 or more		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
G.P.s	221	64	101	63	60	56	25	48	20	49	427	61
Health authority	114	33	50	31	41	38	24	46	19	46	248	35
G.Ps and health authority share	3	1	-	-	-	-	-	-	-	-	3	-
Varies between practices	1	-	9	6	6	6	3	6	2	5	21	3
Total	344[1]	100	160	100	108[2]	100	52	100	41	100	705[3]	100

1. Total includes 5 no answers
2. Total includes 1 no answer
3. Total excludes 5 health centres with no G.Ps

TABLE 40

Persons mentioned as responsible for day-to-day administration in health centres

Title of person	No. of persons mentioned per centre					
	One person		Two persons		Three persons	
	No.	%	No.	%	No.	%
Sector Administrator	25	4.6	26	9.8	9	9
Community Services Administrator	41	7.6	26	9.8	9	9
Miscellaneous	60	11.2	33	12.4	17	17
Hospital, Unit Administrator	21	3.9	15	5.6	2	2
Health Centre Administrator	208	38.7	16	6.0	2	2
Practice Administrator	15	2.8	7	2.6	5	5
Secretary, Receptionist	64	11.9	37	13.9	16	16
Clinic clerk, clerk	80	14.9	42	15.8	15	15
Nurse, health visitor, Nursing Officer	16	3.0	22	8.3	12	12
Domestic supervisor	-	-	25	9.4	3	3
Cleaner, Caretaker	6	1.1	16	6.0	8	8
Other	2	0.4	1	0.4	1	1
Total	538	100	266	100	99	100
	(538 health centres)		(133 health centres)		(33 health centres)	

N.B. In 6 centres, no person was named as responsible for day-to-day administration.

TABLE 41

The number of persons responsible for day-to-day administration in health centres, according to the type of system in health districts/SDAs for administering health centres

No. of persons responsible for day-to-day health centre administration	162 health districts/SDAs with one system - type of system						8 health districts/SDAs with two systems		System not known	TOTAL	
	Geographical		Community		Pragmatic						
	No.	%	No.	%	No.	%	No.	%		No.	%
No answer	-	-	6	2	-	-	-	-	-	6	0.8
1	162	76	286	74	35	88	46	79	9	538	75.8
2	43	20	74	19	5	13	10	17	1	133	18.7
3	9	4	22	6	-	-	2	3	-	33	4.7
Total	214	100	388	100	40	100	58	100	10	710	100

TABLE 42

Health centres where two persons were mentioned as responsible for day-today administration - combinations of titles of persons.

Sector Administrator	Community Services Administrator	Misc. Administrator	Hospital or unit Administrator	Health centre Administrator	Practice Administrator	Secretary or Receptionist	Clinic clerk, clerk	Nurse, H. Vis., Nursing Officer	Domestic Supervisor	Cleaner, caretaker	Other	Total	Titles of persons mentioned
-	-	2	2	-	1	11	1	2	6	1	-	26	Sector Administrator
		8	-	-	-	4	8	3	3	-	-	26	Community Services Administrator
			1	3	2	3	8	-	6	-	-	23	Miscellaneous Administrator
				1	-	2	3	3	-	2	1	12	Hospital, Unit Administrator
					-	3	3	-	4	2	-	12	Health Centre Administrator
						1	-	3	-	-	-	4	Practice Administrator
						1	7	3	-	1	-	12	Secretary, Receptionist
								2	1	9	-	12	Clinic clerk, clerk
									5	1	-	6	Nurses, H.V., Nursing Officer
											-	-	Domestic Supervisor
												-	Cleaner, caretaker
												133	Total no. of combinations

TABLE 43

Health centres where three persons were mentioned as responsible for day-to-day administration in combinations of titles of persons.

Titles of persons mentioned.		No.of times combination occurred
Sector Administrator +	Secretary/receptionist + miscellaneous administrator	4
	Clinic clerk + miscellaneous administrator	3
	Practice administrator + Nurse/Health visitor	1
	Cleaner/caretaker + miscellaneous administrator	1
Community Services Administrator +	Nurse/Health visitor + Secretary/receptionist	1
	Community services administrator + Health centre administrator	1
	Community Services administrator + secretary/ receptionist	2
	Community Services Administrator + Nurse/Health visitor	1
Miscellaneous Administrator +	Hospital Unit Administrator + Practice administrator	1
	Practice administrator + practice administrator	1
	Nurse/Health visitor + domestic supervisor	2
	Miscellaneous administrator + other	1
	Clinic clerk/clerk + cleaner/caretaker	1
	Clinic Clerk/clerk + clinic clerk/clerk	2
Hospital/Unit Administrator +	Cleaner/Caretaker + Secretary/receptionist	1
Health Centre Administrator +	Cleaner/caretaker + cleaner caretaker	1
Practice Administrator +	Cleaner/caretaker + clinic clerk/clerk	1
Secretary/receptionist +	Clinic/clerk + Nurse/Health visitor	5
	Nurse/health visitor + cleaner/caretaker	1
	Nurse/Health visitor + domestic supervisor	1
	Cleaner/caretaker + clerk/clinic clerk	1
Total no. of combinations		33

TABLE 44

Employment arrangements of persons mentioned as responsible for day-to-day administration in health centres

Employment arrangement *	Number of persons mentioned per centre					
	One person		Two persons		Three persons	
	No.	%	No.	%	No.	%
A	187	34.8	49	18.4	15	15
B	29	5.4	2	0.8	1	1
C	83	15.4	24	9.0	2	2
D	75	14.0	60	22.5	34	34
E	35	6.5	24	9.0	7	7
F	84	15.6	71	26.7	22	22
G, H	35	6.5	17	6.4	10	10
I	10	1.9	9	3.4	7	7
No answer	-	-	10	3.8	1	1
Total	538	100	266	100	99	100
	(538 health centres)		(133 health centres)		(33 health centres)	

* For details see chart on page 54

TABLE 45

Health Centres with one person mentioned as responsible for day-to-day administration - their titles and employment arrangements.

Title	Employment category								
	A	B	C	D	E	F	G, H	I	TOTAL
Sector Administrator	-	-	1	-	-	24	-	-	25
Community Services Administrator	1	4	3	-	2	31	-	-	41
Miscellaneous Administrator	-	-	8	-	25	27	-	-	60
Hospital, Unit Administrator	1	-	11	-	7	1	-	1	21
Health Centre Administrator	117	25	46	7	-	-	12	1	208
Practice Administrator	1	-	-	-	-	-	12	2	15
Secretary, Receptionist	33	-	6	12	-	-	10	3	64
Clerk, clinic clerk	28	-	6	43	1	1	1	-	80
Nurse, H.V., Nursing Officer	-	-	2	13	-	-	-	1	16
Cleaner, Caretaker	6	-	-	-	-	-	-	-	6
Other	-	-	-	-	-	-	-	2	2
TOTAL	187	29	83	75	35	84	35	10	538

TABLE 46

Health centres where two persons were mentioned as responsible for day-to-day administration - combinations of employment arrangements.

A	B	C	D	E	F	G,H	I	No answer	Total	Employment category
8	-	1	4	12	14	-	1	1	41	A
		-	-	-	2	-	-	-	2	B
		3	14	-	-	-	1	2	20	C
			3	7	15	8	3	3	39	D
				1	-	2	-	1	4	E
					16	3	4	1	24	F
						2	-	-	2	G,H
								-	-	I
								1	1	No answer
									133	Total no. of combinations

TABLE 47

Health Centres with two persons mentioned as responsible for day-to-day administration - their titles and employment arrangements.

Title	Employment Category									
	A	B	C	D	E	F	G,H	I	No answer	TOTAL
Sector Administrator	-	-	-	-	-	26	-	-	-	26
Community Services Administrator	-	-	6	-	-	20	-	-	-	26
Miscellaneous Administrator	-	-	4	1	8	19	1	-	-	33
Hospital, Unit Administrator	-	2	1	-	12	-	-	-	-	15
Health Centre Administrator	10	-	4	-	-	-	1	1	-	16
Practice Administrator	1	-	-	-	-	-	6	-	-	7
Secretary, Receptionist	17	-	-	10	-	-	7	1	2	37
Clerk, clinic clerk	9	-	-	28	1	-	1	1	2	42
Nurse, H.V.,Nursing Officer	-	-	-	21	-	-	1	-	-	22
Domestic Supervisor	-	-	9	-	3	6	-	4	3	25
Cleaner, Caretaker	12	-	-	-	-	-	-	2	2	16
Other	-	-	-	-	-	-	-	-	1	1
TOTAL	49	2	24	60	24	71	17	9	10	266

TABLE 48

Health centres where three persons were mentioned as responsible for day-to-day administration - combinations of employment arrangements.

	Combination of arrangements				
A +	AA 3	FG 1	DI 2	BD 1	EF 2
C +	DD 1	DI 1			
D +	G No Answer 1	DD 5	FF 6	DE 1	EI 2
	FH 1	HI 1			
E +	GG 1	GI 1			
F +	FG 1	FH 2			
Total no. of combinations	33				

TABLE 49

Health Centres with three persons mentioned as responsible for day-to-day administration - their titles and employment arrangements

Title	Employment Category									
	A	B	C	D	E	F	G,H	I	No answer	TOTAL
Sector Administrator	-	-	-	-	-	9	-	-	-	9
Community Services Administrator	-	-	-	-	1	8	-	-	-	9
Miscellaneous Administrator	3	-	2	-	4	5	1	2	-	17
Hospital, Unit Administrator	-	-	-	-	2	-	-	-	-	2
Health Centre Administrator	1	-	-	-	-	-	1	-	-	2
Practice Administrator	-	-	-	-	-	-	5	-	-	5
Secretary, Receptionist	2	-	-	11	-	-	3	-	-	16
Clerk, clinic clerk	4	-	-	10	-	-	-	1	-	15
Nurse, H.V., Nursing Officer	-	-	-	12	-	-	-	-	-	12
Domestic Supervisor	-	-	-	-	-	-	-	3	-	3
Cleaner, Caretaker	5	1	-	-	-	-	-	1	1	8
Other	-	-	-	1	-	-	-	-	-	1
TOTAL	15	1	2	34	7	22	10	7	1	99

TABLE 50

Titles and salary grades of persons responsible for day-to-day administration in health centres with one person mentioned as responsible

Salary grade	Title of person																					
	Sector Administrator		Community Services Administrator		Misc. Administrator		Hospital Unit Administrator		Health Centre Administrator		Practice Administrator		Secretary, Receptionist		Clinic clerk, clerk		Nurse, HV, Nursing Officer		Cleaner, Caretaker		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Clerical officer	-	-	-	-	-	-	-	-	1	0.5	-	-	11	17	37	46	-	-	-	-	49	9.1
Higher Clerical Officer	-	-	-	-	-	-	-	-	73	35.1	2	13	39	61	38	48	-	-	-	-	152	28.4
General Administrative Assistant	-	-	16	39	36	60	9	43	103	49.5	3	20	2	3	-	-	-	-	-	-	169	31.5
Senior Administrative Assistant	3	12	11	27	19	32	9	43	19	9.1	-	-	-	-	-	-	-	-	-	-	61	11.4
Principal Administrative Assistant	18	72	10	24	5	8	3	14	-	-	-	-	-	-	-	-	-	-	-	-	36	6.7
Miscellaneous secretarial	-	-	-	-	-	-	-	-	-	-	1	7	2	3	1	1	-	-	-	-	4	0.7
Nursing grade	-	-	-	-	-	-	-	-	-	-	1	7	-	-	-	-	15	94	-	-	16	3.0
Caretaking grade	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6	100	6	1.1
Administrative & Professional/Senior Officer (local authority grade)	-	-	-	-	-	-	-	-	6	2.9	-	-	-	-	-	-	-	-	-	-	6	1.1
G.P. employee	-	-	-	-	-	-	-	-	2	1.0	3	20	8	12	1	1	-	-	-	-	14	2.6
Local authority clerical	-	-	-	-	-	-	-	-	2	1.0	-	-	2	3	1	1	-	-	-	-	5	0.9
Executive Officer 1 & 2	-	-	-	-	-	-	-	-	-	-	3	20	-	-	-	-	-	-	-	-	3	0.6
Other	-	-	-	-	-	-	-	-	-	-	1	7	-	-	1	1	-	-	-	-	2	0.4
No answer	4	16	4	10	-	-	-	-	2	1.0	1	7	-	-	1	1	1	6	-	-	13	2.4
Total	25	100	41	100	60	100	21	100	208	100	15	100	64	100	80	100	16	100	6	100	536*	100

*This total excludes two centres with title 'other" and no salary grade given.

TABLE 51

Titles and salary grades of persons responsible for day-to-day administration in health centres with two persons mentioned as responsible

Salary grade	Title of person																					
	Sector Administrator		Community Services Administrator		Misc. Administrator		Hospital Unit Administrator		Health Centre Administrator		Practice Administrator		Secretary, Receptionist		Clinic clerk, clerk		Nurse HV, Nursing Officer		Domestic Supervisor		Cleaner, Caretaker		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Clerical Officer	-	-	-	-	1	3	-	-	-	-	-	-	8	22	22	52	-	-	-	-	-	-	31	11.7
Higher Clerical Officer	-	-	-	-	-	-	-	-	7	44	5	71	19	51	14	33	-	-	-	-	-	-	45	17.0
General Administrative Assistant	-	-	4	15	10	30	3	20	6	38	-	-	-	-	-	-	-	-	-	-	-	-	23	8.6
Senior Administrative Assistant	2	8	8	31	13	39	12	80	-	-	-	-	-	-	-	-	-	-	3	12	-	-	38	14.3
Principal Administrative Assistant	23	88	14	54	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	4	-	-	38	14.3
Miscellaneous secretarial	-	-	-	-	-	-	-	-	-	-	-	-	3	8	2	5	-	-	-	-	-	-	5	2.0
Nursing grade	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	22	100	-	-	-	-	22	8.3
Caretaking grade	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16	100	16	6.0
Administrative & Professional/Senior Officer (local authority grade)	-	-	-	-	-	-	-	-	-	-	-	-	1	3	-	-	-	-	-	-	-	-	1	0.4
G.P. employee	-	-	-	-	1	3.	-	-	1	6	2	29	6	16	-	-	-	-	-	-	-	-	10	3.8
Domestic staff grade	-	-	-	-	7	21.	-	-	-	-	-	-	-	-	-	-	-	-	17	68	-	-	24	9.0
Other	-	-	-	-	-	-	-	-	1	6	-	-	-	-	1	2	-	-	-	-	-	-	2	0.8
No answer	1	4	-	-	1	3.	-	-	1	6	-	-	-	-	3	7	-	-	4	16	-	-	11*	4.1
Total	26	100	26	100	33	100	15	100	16	100	7	100	37	100	42	100	22	100	25	100	16	100	266	100

* Includes one case of 'other' title and no answer for salary grade.

TABLE 52

Titles and salary grades of persons responsible for day-to-day administration in health centres with three persons mentioned as responsible

Salary grade	Title of person												
	Sector Administrator	Community Services Administrator	Misc. Administrator	Hospital Unit Administrator	Health Centre Administrator	Practice Administrator	Secretary, Receptionist	Clinic clerk, clerk	Nurse, HV, Nursing Officer	Domestic Supervisor	Cleaner, Caretaker	Other	Total
Clerical officer	-	-	4	-	-	-	9	14	-	-	-	-	27
Higher Clerical Officer	-	-	-	-	-	1	3	-	-	-	-	-	4
General Administrative Assistant	-	-	6	-	1	-	-	-	-	-	-	-	7
Senior Administrative Assistant	1	5	-	2	-	-	-	-	-	-	-	-	8
Principal Administrative Assistant	3	4	-	-	-	-	-	-	-	-	-	-	7
Nursing grade	-	-	-	-	-	-	-	-	12	-	-	-	12
Caretaking grade	-	-	-	-	-	-	-	-	-	-	6	-	6
Administrative and Professional/Senior Officer (local authority grade)	4	-	4	-	-	-	-	-	-	-	-	-	8
G.P. employee	-	-	-	-	1	2	3	-	-	-	-	-	6
Domestic staff grade	-	-	-	-	-	-	-	-	-	3	-	-	3
Local authority clerical grade	-	-	-	-	-	-	1	-	-	-	-	-	1
Other	-	-	1	-	-	1	-	-	-	-	-	1	3
No answer	1	-	2	-	-	1	-	1	-	-	2	-	7
Total	9	9	17	2	2	5	16	15	12	3	8	1	99

TABLE 53

Salary grades and employment category of persons responsible for day-to-day administration in health centres with one person mentioned as responsible

Salary grade	Employment category																	
	A		B		C		D		E		F		G,H		I	TOTAL		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	No.	%	
Clerical Officer	12	6	-	-	-	-	32	43	-	-	1	1	1	3	3	49	9.1	
Higher Clerical Officer	92	49	7	24	20	24	26	35	1	3	-	-	4	11	2	152	28.2	
General Administrative Assistant	60	32	18	62	38	46	2	3	18	51	24	29	8	23	1	169	31.4	
Senior Administrative Assistant	6	3	4	14	20	24	-	-	13	37	18	21	-	-	-	61	11.3	
Principal Administrative Assistant	-	-	-	-	-	-	-	-	3	9	33	39	-	-	-	36	6.7	
Miscellaneous Secretarial	1	1	-	-	-	-	1	1	-	-	-	-	2	6	-	4	0.7	
Nursing grade	-	-	-	-	2	2	12	16	-	-	-	-	1	3	1	16	3.0	
Caretaker grade	6	3	-	-	-	-	-	-	-	-	-	-	-	-	-	6	1.1	
Administrative and Professional/ Senior Officer (local authority grade)	5	3	-	-	-	-	-	-	-	-	-	-	1	3	-	6	1.1	
G.P. employee	-	-	-	-	-	-	-	-	-	-	-	-	14	40	-	14	2.6	
Local authority clerical	3	2	-	-	2	2	-	-	-	-	-	-	-	-	-	5	0.9	
Executive Officer 1 and 2	1	1	-	-	-	-	-	-	-	-	-	-	1	3	1	3	0.6	
Other	-	-	-	-	-	-	1	1	-	-	-	-	1	3	-	2	0.4	
No answer	1	1	-	-	1	1	1	1	-	-	8	10	2	6	2	15	2.8	
Total	187	100	29	100	83	100	75	100	35	100	84	100	35	100	10	538	100	

TABLE 54

Salary grades and employment category of persons responsible for day-to-day administration in health centres with two persons responsible

Salary grade	Employment category																					
	A		B	C		D		E		F		G,H		I	No answer	Total	
	No.	%	No.	No.	%	No.	%	No.	%	No.	%	No.	%	No.		No.	%
Clerical Officer	6	12	-	-	-	21	35	-	-	-	-	1	6	-	3	31	12
Higher Clerical Officer	24	49	-	-	-	15	25	-	-	-	-	5	29	-	-	44	17
General Administrative Assistant	2	4	2	11	46	-	-	3	13	5	7	-	-	-	-	23	9
Senior Administrative Assistant	1	2	-	1	4	-	-	17	71	21	30	-	-	-	-	40	15
Principal Administrative Assistant	-	-	-	4	17	-	-	-	-	34	48	-	-	-	-	38	14
Miscellaneous secretarial	2	4	-	-	-	1	2	-	-	-	-	2	12	-	-	5	2
Nursing grade	-	-	-	-	-	21	35	-	-	-	-	1	6	-	-	22	8
Caretaker grade	11	22	-	-	-	-	-	-	-	-	-	-	-	2	2	15	6
Administrative and Professional/ Senior Officer (local authority grade)	1	2	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
G.P. employee	1	2	-	-	-	-	-	-	-	-	-	8	47	1	-	10	4
Domestic grade	-	-	-	5	21	-	-	3	13	10	14	-	-	4	2	24	9
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	2	1
No answer	1	2	-	3	13	2	3	1	4	1	1	-	-	3	3	11	4
Total	49	100	2	24	100	60	100	24	100	71	100	17	100	9	10	266	100

TABLE 55

Salary grades and employment categories of persons responsible for day-to-day administration in health centres with three persons responsible

Salary grade	Employment category													
	A		B	C	D		E	F		G,H	I	No answer	Total	
	No.	%	No.	No.	No.	%	No.	No.	%	No.	No.		No.	%
Clerical Officer	8	53	-	-	17	50	-	-	-	-	2	-	27	27
Higher Clerical Officer	-	-	-	-	3	9	-	-	-	1	-	-	4	4
General Administrative Assistant	1	7	-	2	-	-	3	1	5	-	-	-	7	7
Senior Administrative Assistant	-	-	-	-	-	-	3	5	23	-	-	-	8	8
Principal Administrative Assistant	-	-	-	-	-	-	-	7	32	-	-	-	7	7
Nursing grade	-	-	-	-	12	35	-	-	-	-	-	-	12	12
Caretaker grade	4	27	1	-	-	-	-	-	-	-	1	-	6	6
Administrative and Professional/ Senior Officer (local authority grade	-	-	-	-	-	-	-	8	36	-	-	-	8	8
G.P. employee	-	-	-	-	-	-	-	-	-	6	-	-	6	6
Domestic grade	-	-	-	-	-	-	-	-	-	-	3	-	3	3
Local authority clerical grade	1	7	-	-	-	-	-	-	-	-	-	-	1	1
Other	-	-	-	-	1	3	-	-	-	1	1	-	3	3
No answer	1	7	-	-	1	3	1	1	5	2	-	1	7	7
Total	15	100	1	2	34	100	7	22	100	10	7	1	99	100

TABLE 56

Salary grade(s) thought appropriate by HD/SDA by salary grade of selected staff involved in the day-to-day administration of Health Centres for "one person", "two person" and "three person" Health Centres.

For staff with title Health Centre Administrator

Salary grade	Centre type	Salary grades thought appropriate for persons administering health centres										
		No answer	Clerical Officer and Higher Clerical Officer	Higher Clerical Officer	Higher Clerical Officer and General Administrative Assistant	Higher Clerical Officer and Senior Administrative Assistant	General Administrative Assistant	General Administrative Assistant and Senior Administrative Assistant	General Administrative Assistant and Other	Senior Administrative Assistant	Other	Total
No answer	1	1	-	-	-	-	1	-	-	-	-	2
	2	-	-	-	1	-	-	-	-	-	-	1
	3	-	-	-	-	-	-	-	-	-	-	-
Clerical Officer	1	1	-	-	-	-	-	-	-	-	-	1
	2	-	-	-	-	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-	-	-	-	-
Higher Clerical Officer	1	11	6	16	28	3	2	-	-	-	2	68
	2	-	1	4	2	-	-	-	-	-	-	7
	3	-	-	-	-	-	-	-	-	-	-	-
General Administrative Assistant	1	5	-	1	33	2	48	8	4	-	-	101
	2	-	-	-	-	-	6	-	-	-	-	6
	3	1	-	-	-	-	-	-	-	-	-	1
Senior Administrative Assistant	1	-	-	-	2	2	3	9	-	1	-	17
	2	-	-	-	-	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-	-	-	-	-
Administrative and Professional/Senior Officer (Local Authority Grade)	1	-	-	2	2	-	-	1	1	-	-	6
	2	-	-	-	-	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-	-	-	-	-
G.P . Employed	1	-	-	-	-	-	-	2	-	-	-	2
	2	1	-	-	-	-	-	-	-	-	-	1
	3	1	-	-	-	-	-	-	-	-	-	1
Other	1	-	-	-	-	-	-	-	-	-	-	-
	2	1	-	-	-	-	-	-	-	-	-	1
	3	-	-	-	-	-	-	-	-	-	-	-
Local authority clerical grades	1	-	-	2	-	-	-	-	-	-	-	2
	2	-	-	-	-	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-	-	-	-	-
TOTAL	1	18	6	21	65	7	54	20	5	1	2	199*
	2	2	1	4	3	-	6	-	-	-	-	16
	3	2	-	-	-	-	-	-	-	-	-	2

* Total excludes 9 where salary grade thought appropriate was not known

TABLE 57

Salary grade(s) thought appropriate by HD/SDA by salary grade of selected staff involved in the day-to-day administration of Health Centres for "one person", "two person" and "three person" Health Centres.

For staff with title Senior Secretary or Senior Receptionist

Salary grade	Centre type	Salary grades thought appropriate for persons administering health centres							
		No answer	Clerical Officer and Higher Clerical Officer	Higher Clerical Officer	Higher Clerical Officer and General Administrative Assistant	General Administrative Assistant	General Administrative Assistant and Senior Administrative Assistant	General Administrative Assistant and other	TOTAL
Clerical Officer	1	-	-	-	1	-	-	-	1
	2	1	-	-	-	-	-	-	1
	3	2	-	-	-	-	-	-	2
Higher Clerical Officer	1	1	1	1	28	-	-	4	35
	2	11	-	2	1	2	-	-	16
	3	1	-	-	-	-	-	-	1
Miscellaneous Secretarial	1	1	-	-	-	-	-	-	1
	2	-	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-	-
Administrative and Professional/Senior Officer (Local Authority Grade)	1	-	-	-	-	-	-	-	-
	2	1	-	-	-	-	-	-	1
	3	-	-	-	-	-	-	-	-
G.P. Employed	1	4	-	-	-	-	-	-	4
	2	2	-	1	1	-	1	-	5
	3	1	-	-	-	-	-	-	1
Local Authority Clerical Grade	1	-	-	-	-	-	-	2	2
	2	-	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-	-
Other Secretarial/ Clerical	1	-	-	-	1	-	-	-	1
	2	1	-	-	1	-	-	-	2
	3	-	-	-	-	-	-	-	-
TOTAL	1	6	1	1	30	-	-	6	44
	2	16	-	3	3	2	1	-	25
	3	4	-	-	-	-	-	-	4

TABLE 58

Salary grade(s) thought appropriate by HD/SDA by salary grade of selected staff involved in the day-to-day administration of Health Centres for "one person", "two person" and "three person" Health Centres.

For staff with title Secretary or Receptionist.

Salary grade	Centre type	Salary grades thought appropriate for persons administering health centres						
		No answer	Clerical Officer and Higher Clerical Officer	Higher Clerical Officer	Higher Clerical Officer and General Administrative Assistant	Higher Clerical Officer and Senior Administrative Assistant	General Administrative Assistant	TOTAL
Clerical Officer	1	7	-	-	3	-	-	10
	2	4	-	-	1	1	1	7
	3	3	1	-	3	-	-	7
Higher Clerical Officer	1	-	1	-	3	-	-	4
	2	1	1	-	1	-	-	3
	3	1	-	-	1	-	-	2
General Administrative Assistant	1	1	-	-	1	-	-	2
	2	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-
G.P. Employed	1	2	-	1	1	-	-	4
	2	1	-	-	-	-	-	1
	3	2	-	-	-	-	-	2
Local Authority Clerical Grade	1	-	-	-	-	-	-	-
	2	-	-	-	-	-	-	-
	3	-	1	-	-	-	-	1
Other secretarial/ receptionist	1	-	-	-	-	-	-	-
	2	-	-	1	-	-	-	1
	3	-	-	-	-	-	-	-
TOTAL	1	10	1	1	8	-	-	20
	2	6	1	1	2	1	1	12
	3	6	2	-	4	-	-	12

TABLE 59

Salary grade(s) thought appropriate by HD/SDA by salary grade of selected staff involved in the day-to-day administration of Health Centres for "one person", "two person" and "three person" Health Centres.

For staff with title Clerk/Clinic Clerk

Salary grade	Centre type	Salary grades thought appropriate for persons administering health centres							
		No answer	Clerical Officer and Higher Clerical Officer	Higher Clerical Officer	Higher Clerical Officer and General Administrative Assistant	Higher Clerical Officer and Senior Administrative Assistant	General Administrative Assistant	General Administrative Assistant and Senior Administrative Assistant	TOTAL
No answer	1	-	-	-	1	-	-	-	1
	2	1	-	-	1	-	1	-	3
	3	1	-	-	-	-	-	-	1
Clerical Officer	1	21	7	3	5	1	-	-	37
	2	4	8	1	2	-	7	-	22
	3	4	2	-	4	-	4	-	14
Higher Clerical Officer	1	15	-	5	15	1	2	-	38
	2	8	-	3	2	-	-	-	13
	3	-	-	-	-	-	-	-	-
G.P. Employed	1	1	-	-	-	-	-	-	1
	2	-	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-	-
Other	1	-	-	1	-	-	-	-	1
	2	-	-	1	-	-	-	-	1
	3	-	-	-	-	-	-	-	-
Local Authority Clerical Grade	1	-	-	1	-	-	-	-	1
	2	-	-	-	-	-	-	-	-
	3	-	-	-	-	-	-	-	-
Other Secretarial/ Clerical	1	-	-	-	1	-	-	-	1
	2	1	-	-	-	-	-	1	2
	3	-	-	-	-	-	-	-	-
TOTAL	1	37	7	10	22	2	2	-	80
	2	14	8	5	5	-	8	1	41
	3	5	2	-	4	-	4	-	15

TABLE 60

Title of those administering health centres by who pays their salary in health centres where one person is mentioned as responsible for the day-to-day administration

Title	G.P.s. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more		
Sector Administrator	-	-	-	-	-	-	25	25
Community Service Administrator	-	-	-	-	1	2	38	41
Miscellaneous Administrator	-	-	-	-	-	-	60	60
Hospital , Unit Administrator	-	-	-	-	-	-	21	21
Health Centre Administrator	9	17	9	8	40	32	93	208
Practice Administrator	8	1	1	3	1	1	-	15
Secretary, Receptionist	10	1	9	10	6	5	23	64
Clinic clerk, clerk	1	2	4	5	5	2	61	80
Nurse , H.V., Nursing Officer	-	-	1	-	-	-	15	16
Cleaner , caretaker	-	-	-	-	2	4	-	6
Total	28	21	24	26	55	46	336	536*

*Total excludes two cases where the person responsible was a G.P. in the health centre.

TABLE 61

Title of those administering health centres by who pays their salary in health centres where two persons are mentioned as responsible for the day-to-day administration

Title	G.P.s. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	No answer	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more			
Sector Administrator	-	-	-	-	-	-	26	-	26
Community Service Administrator	-	-	-	-	-	-	26	-	26
Miscellaneous Administrator	1	1	-	-	-	1	30	-	33
Hospital , Unit Administrator	-	-	-	-	-	-	15	-	15
Health Centre Administrator	1	1	-	1	1	1	11	-	16
Practice Administrator	4	1	-	-	-	-	1	1	7
Secretary , Receptionist	10	6	10	-	1	2	7	1	37
Clinic clerk, clerk	2	2	1	4	1	1	31	-	42
Nurse , H.V ., Nursing Officer	1	-	-	-	-	-	20	1	22
Domestic Supervisor	-	-	-	-	-	-	24	1	25
Cleaner, caretaker	-	1	-	-	1	-	13	1	16
Other	-	-	-	-	-	-	1	-	1
Total	19	12	11	5	4	5	205	5	266

TABLE 62

Title of those administering health centres by who pays their salary in health centres where three persons are mentioned as responsible for the day-to-day administration

Title	G.P.s. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more		
Sector Administrator	-	-	-	-	-	-	9	9
Community Service Administrator	-	-	-	-	-	-	9	9
Miscellaneous Administrator	-	1	1	-	1	1	13	17
Hospital and Unit Administrator	-	-	-	-	-	-	2	2
Health Centre Administrator	-	-	1	-	1	-	-	2
Practice Administrator	5	-	-	-	-	-	-	5
Secretary, Receptionist	3	1	-	1	-	5	6	16
Clinic clerk, clerk	-	-	-	1	-	-	14	15
Nurse, H.V., Nursing Officer	-	-	-	-	-	-	12	12
Domestic supervisor	-	-	-	-	-	-	3	3
Cleaner, caretaker	-	-	2	-	-	-	6	8
Other	-	-	-	-	-	-	1	1
Total	8	2	4	2	2	6	75	99

TABLE 63

Who pays the salary of persons mentioned as responsible for the day-to-day administration of health centres by employment category of these persons, for health centres where one person was mentioned as being responsible for day-to-day administration.

Employment category (see page 54)	G.Ps. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more		
A	1	11	15	13	39	25	83	187
B	-	6	-	-	1	7	15	29
C	-	1	1	2	3	9	67	83
D	-	-	6	7	8	4	50	75
E	-	-	-	-	-	1	34	35
F	-	-	-	-	-	-	84	84
G, H	27	3	2	2	1	-	-	35
I	-	-	-	2	3	-	3	10*
Total	28	21	24	26	55	46	336	538*

* Total including two cases where the person mentioned as being responsible for the day-to-day administration was a general practitioner in the health centre

TABLE 64

Who pays the salary of persons mentioned as responsible for the day-to-day administration of health centres by employment category of these persons, for health centres where two persons were mentioned as being responsible for day-to-day administration

Employment category (see page 54)	G.Ps. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	No answer	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more			
A	4	4	9	1	3	3	25	-	49
B	-	-	-	-	-	-	2	-	2
C	-	-	-	-	-	-	24	-	24
D	1	2	2	4	1	1	48	1	60
E	-	1	-	-	-	1	22	-	24
F	-	1	-	-	-	-	70	-	71
G, H	12	2	-	-	-	-	1	2	17
I	1	1	-	-	-	-	7	-	9
No answer	1	1	-	-	-	-	6	2	10
Total	19	12	11	5	4	5	205	5	266

TABLE 65

Who pays the salary of persons mentioned as responsible for the day-to-day administration of health centres by employment category of these persons, for health centres where three persons were mentioned as being responsible for day-to-day administration.

Employment category (see page 54)	G.Ps. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more		
A	-	-	3	2	2	-	8	15
B	-	-	-	-	-	-	1	1
C	-	-	-	-	-	-	2	2
D	-	1	-	-	-	5	28	34
E	-	-	-	-	-	-	7	7
F	-	-	-	-	-	-	22	22
G, H	8	1	1	-	-	-	-	10
I	-	-	-	-	-	1	6	7
No answer	-	-	-	-	-	-	1	1
Total	8	2	4	2	2	6	75	99

TABLE 66

Who pays the salary of persons mentioned as responsible for the day-to-day administration of health centres by salary grade of these persons, for health centres where one person was mentioned as being responsible for day-to-day administration.

Salary grade	G.Ps. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more		
Clerical Officer	1	-	1	1	4	2	40	49
Higher Clerical Officer	2	8	15	17	34	11	65	152
General Administrative Assistant	6	10	5	4	12	19	113	169
Senior Administrative Assistant	-	1	-	-	1	8	51	61
Principal Administrative Assistant	-	-	-	-	-	-	36	36
Miscellaneous secretarial	3	-	-	-	-	-	1	4
Nursing grade	1	-	1	-	-	-	14	16
Caretaking grade	-	-	-	-	2	4	-	6
Administrative & Professional/Senior Officer (local authority grade)	-	2	1	-	-	1	2	6
G.P. employee	12	-	-	2	-	-	-	14
Local authority clerical grade	-	-	-	-	2	-	3	5
Executive Officer 1 & 2	1	-	-	1	-	1	-	3
Other	-	-	1	-	-	-	1	2
No answer	2	-	-	1	-	-	10	15*
Total	28	21	24	26	55	46	336	538*

* Total including two cases where the person mentioned as being responsible for the day-to-day administration was a general practitioner in the health centre

TABLE 67

Who pays the salary of persons mentioned as responsible for the day-to-day administration of health centres by salary grade of these persons for health centres where two persons were mentioned as being responsible for day-to-day administration.

Salary grade	G.Ps. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	No answer	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more			
Clerical Officer	1	2	1	-	1	1	24	1	31
Higher Clerical Officer	2	7	10	4	1	2	18	1	45
General Administrative Assistant	-	-	-	-	1	2	20	-	23
Senior Administrative Assistant	-	1	-	-	-	-	37	-	38
Principal Administrative Assistant	-	-	-	-	-	-	38	-	38
Miscellaneous secretarial	3	-	-	-	-	-	2	-	5
Nursing grade	1	-	-	-	-	-	20	1	22
Caretaking grade	-	1	-	-	1	-	13	1	16
Administrative & Professional/Senior Officer (local authority grade)	1	-	-	-	-	-	-	-	1
G.P. Employee	10	-	-	-	-	-	-	-	10
Domestic staff grade	-	-	-	-	-	-	24	-	24
Other	-	1	-	-	-	-	1	-	2
No answer	1	-	-	1	-	-	8	1	11
Total	19	12	11	5	4	5	205	5	266

TABLE 68

Who pays the salary of persons mentioned as responsible for the day-to-day administration of health centres by salary grade of these persons, for health centres where three persons were mentioned as being responsible for day-to-day administration.

Salary grade	G.Ps. pay all	Health authority divides cost with G.Ps. Percentage paid by health authority					Health authority pays all	Total
		% age not known	less than 30%	30-49%	50-69%	70% or more		
Clerical Officer	-	-	1	2	1	3	20	27
Higher Clerical Officer	1	1	-	-	-	2	-	4
General Administrative Assistant	-	-	-	-	1	-	6	7
Senior Administrative Assistant	-	-	-	-	-	-	8	8
Principal Administrative Assistant	-	-	-	-	-	-	7	7
Nursing grade	-	-	-	-	-	-	12	12
Caretaking grade	-	-	2	-	-	-	4	6
Administrative & Professional/Senior Officer (local authority grade)	-	-	-	-	-	-	8	8
G. P. Employee	5	-	1	-	-	-	-	6
Domestic staff grade	-	-	-	-	-	-	3	3
Local authority clerical grade	-	-	-	-	-	-	1	1
Other	1	-	-	-	-	1	1	3
No answer	1	1	-	-	-	-	5	7
Total	8	2	4	2	2	6	75	99

TABLE 69

Whether or not salary cost of selected staff for one person, two person and three person centres was paid entirely by the HD/SDA, or entirely by the general practitioners in the health centre or shared, by the preferences on this matter expressed by respondents from the HDs/SDAs.

For staff with title Health Centre Administrator

Payment of salary costs	* Centre type	Preference of HD/SDA					
		Not applicable	No answer	HD/SDA to pay whole	G.P. to pay some part	Don't mind	TOTAL
HD/SDA pays all	1	1	2	77	13	-	93
	2	1	-	9	-	1	11
	3	-	-	-	-	-	-
G.Ps pay all	1	6	-	1	2	-	9
	2	1	-	-	-	-	1
	3	-	-	-	-	-	-
HD/SDA and G.Ps share							
(i) % paid by HD/SDA known	1	13	4	14	54	4	89
	2	-	-	1	2	-	3
	3	1	1	-	-	-	2
(ii) % paid by HD/SDA not known	1	-	-	-	13	2	15
	2	-	-	-	1	-	1
	3	-	-	-	-	-	-
(iii) % paid by HD/SDA not agreed	1	-	1	-	1	-	2
	2	-	-	-	-	-	-
	3	-	-	-	-	-	-
TOTAL	1	20	7	92	83	6	208
	2	2	-	10	3	1	16
	3	1	1	-	-	-	2

* Whether a one person, two person or three person centre.

TABLE 70

Whether or not salary cost of selected staff for one person, two person and three person centres was paid entirely by the HD/SDA, or entirely by the general practitioners in the health centre or shared, by the preferences on this matter expressed by respondents from the HD /SDAs

For staff with title Clerk /Clinic Clerk

Payment of salary costs	Centre type *	Preference of HD/SDA					
		Not applicable	No answer	HD/SDA to pay whole	G.P. to pay some part	Don't mind	TOTAL
HD/SDA pays all	1	13	10	26	5	7	61
	2	2	6	8	9	6	31
	3	2	3	4	5	-	14
G.P_s pay all	1	-	1	-	-	-	1
	2	2	-	-	-	-	2
	3	-	-	-	-	-	-
HD/SDA and G.Ps share							
(i) % paid by HD/SDA known	1	11	-	1	4	-	16
	2	5	-	1	1	-	7
	3	-	-	-	1	-	1
(ii) % paid by HD/SDA not known	1	-	2	-	-	-	2
	2	-	-	-	2	-	2
	3	-	-	-	-	-	-
(iii) % paid by HD/SDA not agreed	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	-	-	-	-	-	-
TOTAL	1	24	13	27	9	7	80
	2	9	6	9	12	6	42
	3	2	3	4	6	-	15

* Whether a one person, two person or three person centre

TABLE 71

Whether or not salary cost of selected staff for one person, two person and three person centres was paid entirely by the HD/SDA, or entirely by the general practitioners in the health centre or shared, by the preferences on this matter expressed by respondents from the HD/SDAs

For staff with title Senior Secretary/Senior Receptionist and Secretary/Receptionist.

Payment of salary costs	** Centre type	Preference of HD/SDA					
		Not applicable	No answer	HD/SDA to pay whole	G.P. to pay some part	Don't mind	TOTAL
HD/SDA pays all	1	-	3	14	5	1	23
	2	2	3	1	1	-	7
	3	4	1	-	1	-	6
G.P.s pay all	1	6	1	1	1	1	10
	2	2	2	1	4	1	10
	3	2	1	-	-	-	3
HD/SDA and G.Ps share							
(i) % paid by HD/SDA known	1	1	4	6	19	-	30
	2	11	-	2	1	-	14
	3	-	1	-	5	-	6
(ii) % paid by HD/SDA not known	1	-	1	-	-	-	1
	2	-	1	2	1	-	4
	3	1	-	-	-	-	1
(iii) % paid by HD/SDA not agreed	1	-	-	-	-	-	-
	2	-	-	-	1	-	1
	3	-	-	-	-	-	-
TOTAL	1	7	9	21	25	2	64
	2	15	6	6	9*	1	37*
	3	7	3	-	6	-	16

* Includes one 'no answer.'

** Whether a one person, two person or three person centre

TABLE 72

Whether or not salary cost of selected staff for one person, two person and three person centres was paid entirely by the HD/SDA, or entirely by the general practitioners in the health centre or shared by the preferences on this matter expressed by respondents from the HD /SDAs.

For staff with title Practice Administrator

Payment of salary costs	Centre type **	Preference of HD/SDA					
		Not applicable	No answer	HD/SDA to pay whole	G.P. to pay some part	Don't mind	TOTAL
HD/SDA pays all	1	-	-	-	-	-	-
	2	-	-	1	-	-	1
	3	-	-	-	-	-	-
G.Ps pay all	1	3	2	2	1	-	8
	2	2	-	1	1	-	4
	3	2	-	-	3	-	5
HD/SDA and G.Ps share							
(i) % paid by HD/SDA known	1	2	-	-	4	-	6
	2	-	-	-	-	-	-
	3	-	-	-	-	-	-
(ii) % paid by HD/SDA not known	1	-	-	-	1	-	1
	2	-	-	1	-	-	1
	3	-	-	-	-	-	-
(iii) % paid by HD/SDA not agreed	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	-	-	-	-	-	-
TOTAL	1	5	2	2	6	-	15
	2	2	-	4*	1	-	7*
	3	2	-	-	3	-	5

* Includes one 'no answer.'

** Whether a one person, two person or three person centre

TABLE 73

Previous experience (type of job) for selected persons responsible for day-to-day administration of health centres by number of persons involved in administration of centre

Type of previous experience	No. of persons involved in administration	Type of staff					
		Health Centre Administrator	Practice Administrator	Secretary, Receptionist inc. Senior Secretary, Receptionist	Clinic Clerk, Clerk	Community Services Administrator	Total
Nursing[1]	1	8	4	4	1	-	17
	2	1	2	2	1	-	6
	3	-	-	-	-	-	-
Administrative or Supervisory, plus Receptionist[2]	1	1	-	-	-	-	1
	2	1	-	-	-	-	1
	3	-	-	-	-	-	-
Administrative or Supervisory[3]	1	56	3	1	2	24	86
	2	1	1	-	-	12	14
	3	-	2	1	-	5	8
Receptionist[4]	1	9	3	14	7	-	33
	2	-	-	9	7	-	16
	3	-	-	1	-	-	1
Secretary and/or Typist and/or Clerical[5]	1	96	4	29	59	14	202
	2	9	3	12*	23	3	50
	3	1	1	9	13	-	24
Other[6]	1	38	1	16	11	3	69
	2	4	1	14	11	11	41
	3	1	2	5	2	4	14
Total	1	208	15	64	80	41	408
	2	16	7	37	42	26	128
	3	2	5	16	15	9	47

1. includes nursing plus any or all other types of work experience
2. includes persons with both administrative or supervisory experience and receptionist experience and any other kind of experience except nursing.
3. includes those with administrative or supervisory experience and any other experience except receptionist and nursing experience.
4. includes those with receptionist experience and any other experience except nursing or administrative or supervisory experience.
5. includes those with secretary/typing or clerical experience and any other experience except nursing, administrative or supervisory or receptionist experience.
6. includes all other categories of experience not included under 1-5 above or none at all

* includes two deputy health centre administrators.

TABLE 74

Whether previous work experience (if any) of those indicated as responsible for the day-to-day administration of health centres included experience of work in the Health Service (including General Practice) - by job title and for one, two and three person centres.

Title of persons responsible for the day-to-day administration.	One Person Centres		Two Person Centres		Three Person Centres		All Centres		
	No. of staff with Health Services work experience[1]	Total staff	No. of staff with Health Services work experience[1]	Total staff	No. of staff with Health Services work experience[1]	Total staff	No. of staff with Health Services work experience (%)[1]		Total staff on which % is based
Sector Administrator	24	25	24	26	3	9	51	(85)	60
Community Services Administrator	19	41	19	26	5	9	43	(57)	76
Miscellaneous Administrator	39	60	14	33	5	17	58	(53)	110
Hospital, Unit Administrator	11	21	14	15	2	2	27	(71)	38
Health Centre Administrator	119	208[2]	10	16	-	2	129	(57)	226[2]
Practice Administrator	11	15	3	7	-	5	14	(52)	27
Secretary, Receptionist	36	64	14	37	6	16	56	(48)	117
Clinic Clerk, Clerk	26	80	17	42	3	15	46	(36)	137
Domestic Supervisor	-	-	8	25	-	3	8	(29)	28
Cleaner, Caretaker	-	6	1	16	-	8	1	(3)	30
Other	-	2	-	1	-	1	-	(-)	4

[1] Staff were included in this category where the description of previous job or jobs indicated that at least one of these jobs was within the Health Services (including General Practice)

[2] Includes five staff with Social Services but not apparently Health Services experience.

[3] Not included in this table are Nurses, Health Visitors and Nursing Officers with responsibility for day-to-day administration as by definition all will have previous Health Service experience of some kind in their training at least.

TABLE 75

Type of Health Services and Local Government experience in previous jobs for staff with responsibility for day-to-day administration for Health Centres - for staff from Centres with one, two or three persons responsible for their administration.

Title of Administrator	No. of persons responsible for administration of Centre.	Type of previous experience in health services or local government.						
		General Practice	Community Health Services	Hospital	Other and unspecified health services experience (excluding local gov't experience)	Local Government experience: All types	Local Government experience: Those with health service experience definitely indicated	All staff with indicated job title.
Sector Administrator	1	-	5	9	6	4	4	25
	2	-	-	15	1	9	8	26
	3	-	-	1	2	5	-	9
Community Services Administrator	1	-	2^{2H}	11	$4\ 8^{7L}$	23	2	41
	2	-	-	4		14	7	26
	3	-	1	4	-	-	-	9
Miscellaneous Administrator	1	-	-	11	1	40	27	60
	2	-	1	3	8	12	2	33
	3	-	-	3	2	6	-	17
Hospital, Unit Administrator	1	-	-	4	6^{L}	10	1	21
	2	-	-	2	8^{L}	4	4	15
	3	-	-	1	1	-	-	2
Health Centre Administrator	1	25^{2C3HUL}	21^{U5L}	26^{3U2L}	29^{7L}	59	18	208
	2	3	1	1^{L}	1^{L}	4	4	16
	3	-	-	-	-	-	-	2
Practice Administrator	1	4	-	1^{U}	6	-	-	15
	2	1	-	1	1	-	-	7
	3	-	-	-	-	-	-	5
Secretary, Receptionist	1	17^{L}	1	6^{2L}	8^{2L}	13	4	64
	2	7	-	7	-	5	-	37
	3	2	-	1	1	2	2	16
Clinic Clerk, Clerk	1	7^{U}	5_{H}	6^{U}	3	35	5	80
	2	5^{H}	2^{H}	3^{U}	4	15	3	42
	3	-	-	-	1	5	2	15
Nurse, Health Visitor, Nursing Officer	1	1^{H}	5^{5H}	10^{5U}	-	-	-	16
	2	-	-	16^{11U3L}	-	3	1	22
	3	-	1^{H}	11^{8U}	-	-	-	12
Cleaner, Caretaker	1	-	-	-	-	2	-	6
	2	-	-	1	-	5	-	16
	3	-	-	-	-	1	-	8
Domestic Supervisor	1	-	-	-	-	-	-	-
	2	-	-	5	3^{3L}	-	-	25
	3	-	-	-	-	-	-	3

See next page for notes on this table.

NOTES TO ACCOMPANY TABLE 75

1. 'General practice experience' includes those with work experience in the sphere of general practice with or without experience additionally in one or other of'community health services','hospital', 'other/unspecified health services (excluding local government)', or 'local government'. The superscript above the number entered in the general practice column for a particular job type indicates the numbers of those who have had work experience additional to that of general practice. For example the entry 25^{2C3HUL} indicates that for health centre administrators from 'one person' centres, 25 had previous experience of general practice and among these, two had, in addition, work experience in the community health services, 3 hospital experience, 1 other/unspecified health services experience (excluding local government) and one local government experience. As in this survey only two previous jobs were coded, those with additional work experience would all be different people, i.e. it would not be possible to have community health services experience and hospital experience in addition to general practice experience. (Two jobs were coded because almost always no more than two previous jobs per person were entered in response to the open question in the questionnaire).

2. Community health services experience includes those with community health service experience with or without any hospital experience, other/unspecified (excluding local government) or local government experience. (The numbers with such additional experience are indicated by the same kind of superscript system as that described in Note 1 above).

3. Those with hospital experience are those with hospital experience with or without other/unspecified health services experience (excluding local government) or local government experience. The numbers with such additional experience are indicated using the superscript system described in Note 1 above.

4. Other and unspecified health services experience (excluding local government) includes those with other / unspecified health service experience (excluding local government) with or without (in another job), local government experience. This additional experience is indicated as explained in Note 1.

5. Local government experience includes those who have only had local government experience and none of the other types of experience mentioned above.

TABLE 76

Type of experience outside Health Services and/or Local Government in previous jobs for those with and without health service and/or local government experience in previous jobs for selected staff with day-to-day responsibilities for health centre administration - for Centres where one, two and three persons were responsible for their administration.

Title of administrator	No. of persons responsible for admin. of centre	Type of previous experience													
		Those with health services and/or local government previous experience							Those without health services and/or local government previous experience.						
		Armed forces	Nationalised industry	Other public service	Private industry	Other	None or none stated	All	Armed forces	Nationalised industry	Other public service	Private industry	Other	None or none stated	All
Sector Administrator	1	-	-	-	-	-	24	24	-	-	-	-	-	1	1
	2	-	-	-	-	-	25	25	-	-	-	-	-	1	1
	3	-	-	-	-	-	8	8	-	-	-	-	-	1	1
Community Services Administrator	1	2	-	-	-	-	38	40	-	-	-	-	-	1	1
	2	-	-	-	-	-	26	26	-	-	-	-	-	-	-
	3	-	-	-	-	-	5	5	-	-	-	4	-	-	4
Miscellaneous Administrator	1	-	-	-	-	-	52	52	-	-	-	-	-	8	8
	2	6	-	-	-	-	18	24	-	-	-	-	1	8	9
	3	-	-	-	-	-	11	11	-	-	-	-	-	6	6
Hospital, Unit Administrator	1	1	-	-	-	-	19	20	-	-	1	-	-	-	1
	2	-	-	-	-	-	14	14	-	-	-	-	-	1	1
	3	-	-	-	-	-	2	2	-	-	-	-	-	-	-
Health Centre Administrator	1	-	1	1	1	1	156	160	9 *	1 *	5	8	6	19	48
	2	-	-	-	-	-	10	10	1	-	-	2	-	3	6
	3	-	-	-	-	-	-	-	1	-	-	1	-	-	2
Practice Administrator	1	-	-	-	-	-	11	11	2	-	1	-	-	1	4
	2	1	-	-	-	-	2	3	-	-	-	-	-	4	4
	3	-	-	-	-	-	-	-	1	-	1	1	-	2	5
Secretary, Receptionist	1	-	-	-	3	-	42	45	1	1	4	4	1	8	19
	2	-	-	-	-	-	19	19	-	-	-	1	-	17	18
	3	-	-	-	-	-	6	6	-	-	-	-	-	10	10
Clinic clerk, clerk	1	-	-	-	-	-	56	56	-	-	1	3	-	20	24
	2	-	-	-	1	-	28	29	1	-	-	3	1	8	13
	3	-	-	-	-	-	6	6	-	-	6	3	-	-	9
Nurse, Health Visitor, Nursing Officer	1	-	-	-	-	-	16	16	-	-	-	-	-	-	-
	2	-	-	-	-	-	22	22	-	-	-	-	-	-	-
	3	-	-	-	-	-	12	12	-	-	-	-	-	-	-
Cleaner, Caretaker	1	-	-	-	-	-	2	2	-	-	-	-	-	4	4
	2	1	-	-	-	-	5	6	1	-	-	-	1	8	10
	3	-	-	-	-	-	1	1	1	-	1	-	-	5	7
Domestic supervisor	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	2	-	-	-	-	-	8	8	-	-	-	-	-	17	17
	3	-	-	-	-	-	-	-	-	-	-	-	-	3	3

Note: Where no answer at all was given to the question about previous experience, this has been entered in the column 'none or not stated' in the section for those without health services and/or local government previous experience.

* Includes 1 with experience in private industry.

TABLE 77

The person to whom those who are mentioned as responsible for day-to-day administration of health centres are accountable, by title of those responsible, for centres where one, two or three persons are responsible.

Title of those responsible for day-to-day administration of health centres	One person centres				Two person centres				Three person centres			
	Person to whom accountable				Person to whom accountable				Person to whom accountable			
	G.Ps	An administrator in the district or area	An 'other' person	No answer	G.Ps	An administrator in the district or area	An 'other' person	No answer	G.Ps	An administrator in the district or area	An 'other' person	No answer
Sector Administrator	-	25	-	-	-	26	-	-	-	9	-	-
Community Services Administrator	-	39	1	1	-	26	-	-	-	9	-	-
Miscellaneous Administrator	-	60	-	-	1	29	-	3	-	12	3	2
Hospital, Unit Administrator	-	21	-	-	-	13	2	-	-	2	-	-
Health Centre Administrator	10	198	-	-	2	14	-	-	1	1	-	-
Practice Administrator	12	2	1	-	7	-	-	-	5	-	-	-
Secretary, Receptionist	10	54	-	-	12	23	-	2	7	9	-	-
Clinic clerk, Clerk	1	79	-	-	2	33	4	3	-	11	4	-
Nurse, H.V., Nursing Officer	-	5	10	1	1	2	17	2	-	1	11	-
Domestic Supervisor	-	-	-	-	-	13	8	4	-	3	0	-
Cleaner, caretaker	-	6	-	-	-	4	11	1	-	2	3	3
Other	1	-	1[1]	-	-	-	-	1	-	-	1	-
Total	34	489	13	2	25	183	42	16	13	59	22	5

[1] Accountable to a Health Centre House Committee

TABLE 78

Titles of the "administrator in the district" or "other person" to whom selected categories of persons responsible for day-to-day administration in the health centre are directly accountable for centres with one person responsible.

Title of person responsible for day to day administration	Title of person to whom accountable																
	Clerk Receptionist Secretary	Administrator unspecified	General Administrative Assistant	Assistant Community Services Administrator	Unit Administrator	Senior Administrative Assistant	Community Services Administrator	Principal Administrative Assistant	Deputy Sector Administrator	Sector Administrator	General Administrator	Operational Services Manager	Divisional Manager	Deputy District Administrator	Nursing Officer	Other	No answer	Total
Health Centre Administrator	-	2	-	7	12	6	46	1	2	89	5	4	2	2	-	1	19	196
Secretary, Receptionist	-	-	3	-	7	2	4	-	7	14	1	-	-	7	-	-	9	54
Clinic Clerk, Clerk	1	8	1	-	10	10	19	1	1	22	-	-	-	1	-	-	5	79
Nurse, H.V. Nursing Officer	-	-	-	-	-	-	1	-	-	4	-	-	-	-	9	-	1	15
Cleaner, Caretaker	-	-	-	-	-	6	-	-	-	-	-	-	-	-	-	-	-	6
Total	1	10	4	7	29	24	70	2	10	129	6	4	2	10	9	1	34	352

TABLE 79

Titles of the "administrator in the district" or "other person" to whom selected categories of persons responsible for day-to-day administration in the health centre are directly accountable, for centres with two persons responsible.

Title of person responsible for day to day administration	Title of person to whom accountable													
	General Administrative Assistant	Unit Administrator	Senior Administrative Assistant	Community Services Administrator	Deputy Sector Administrator	Sector Administrator	Operational Services Manager	Domestic Services Manager	Deputy District Administrator	District Administrator	Nursing Officer	Other	No Answer	Total
Health centre Administrator	2	-	-	6	-	3	1	-	-	-	-	-	2	14
Secretary, Receptionist	-	1	3	2	1	12	1	-	1	-	-	-	2	23
Clinic clerk, Clerk	1	3	9	3	3	10	-	-	1	1	-	4	2	37
Nurse, H.V., Nursing Officer	-	-	-	-	-	-	-	-	-	-	19	-	-	19
Domestic Supervisor	-	-	-	-	-	1	3	16	1	-	-	-	-	21
Cleaner, Caretaker	-	1	-	-	-	1	-	11	-	-	-	-	2	15
Total	3	5	12	11	4	27	5	27	3	1	19	4	8	129

TABLE 80

Titles of the "administrator in the district or "other person" to whom selected categories of persons responsible for day-to-day administration in the health centre are directly accountable for centres with three persons responsible.

Title of person responsible for day to day administration	Title of person to whom accountable									
	Unit Administrator	Community Services Administrator	Deputy Sector Administrator	Sector Administrator	General Administrator	Domestic Services Manager	Nursing Officer	Other	No answer	Total
Health centre administrator	-	1	-	-	-	-	-	-	-	1
Secretary, Receptionist	1	1	3	3	1	-	-	-	-	9
Clinic clerk, clerk	--	-	3	4	-	-	-	4	4	15
Nurse, Health Visitor, Nursing Officer	-	-	-	1	-	-	11	-	-	12
Domestic Supervisor	-	-	-	2	-	-	-	-	1	3
Cleaner, Caretaker	1	-	-	1	-	3	-	-	-	5
Total	2	2	6	11	1	3	11	4	5	45

TABLE 81

Whether or not those responsible for day-to-day administration participated in regular meetings with other staff in the district (or area in single district areas) - for selected job titles for centres where one person, two persons and three persons are responsible

Job title of staff with day-to-day administrative responsibility for health centres	One person centres					Two person centres					Three person centres				
	Participated in meetings					Participated in meetings					Participated in meetings				
	Yes		No		All	Yes		No		All	Yes		No		All
	No.	%	No.	%	100%	No.	%	No.	%	100%	No.	%	No.	%	100%
Health Centre Administrator	112	54	96	46	208	7	44	9	56	16	1		1		2
Practice Administrator	-	-	15	100	15	-	-	7	100	7	-	-	5	-	5
Secretary, Receptionist	14	22	50	78	64	1	3	36	97	37	-	-	16	100	16
Clinic Clerk, Clerk	28	35	52	65	80	6	14	36	86	42	-	-	15	100	15
All the above categories of staff	154	42	213	58	367	14	14	88	86	102	1	3	37	97	38

TABLE 82

Regular meetings with other staff in district (or area in single district areas) most commonly attended by indicated types of staff with day-to-day administration responsibilities for health centres - for centres where one person, two person or three persons are responsible /Note some staff attend two sorts of meeting/

Title of staff with day-to day administrative responsibilities for health centres	Type of Centre	Type of Meeting Attended														All Staff (100%)
		Meeting of Clinic Clerks		Meeting of Health Centre Administrators, Supervisors & Secretaries		Meeting of Unit Administrators		Meeting of Community Health Service Administrators		Meeting of Sector Staff		Meeting of District Staff		Multi-disciplinary meetings		
		No	%	No	%	No	%	No	%	No	%	No	%	No	%	
Health Centre Administrator	One person	5	2	20	10	23	11	10	5	22	11	12	6	10	5	208
	Two person	-	-	-	-	-	-	-	-	4	-	1	-	1	-	16
	Three person	-	-	-	-	-	-	-	-	1	-	-	-	2	-	2
Secretary, Receptionist	One person	-	-	11	17	-	-	-	-	-	-	-	-	1	2	64
	Two person	-	-	-	-	-	-	-	-	1	3	-	-	0	-	37
	Three person	-	-	-	-	-	-	-	-	-	-	-	-	0	-	16
Clinic Clerk, Clerk	One person	3	4	7	9	2	3	1	1	9	11	2	3	3	4	80
	Two person	-	-	-	-	-	-	1	2	1	2	-	-	-	-	42
	Three person	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15
All the above categories of staff	One person	8	2	38	11	25	7	11	3	31	9	14	4	14	4	352
	Two person	-	-	-	-	-	-	1	1	6	6	1	1	1	1	95
	Three person	-	-	-	-	-	-	-	-	1	3	-	-	2	6	33

TABLE 83

Role on the house committee (where it exists) of person responsible for day-to-day administration in centres where one person is responsible

Title	Role on House Committee													
	Member		Secretary		Convenor	Chairman	Other		No role		No answer	Total		
	No.	%	No.	%	No.	No.	No.	%	No.	%	No.	No.	%	
Sector Administrator	3	5	2	1	-	1	1	4	-	-	1	8	2.7	
Community Services Administrator	1	2	4	3	4	1	-	-	1	2	-	11	3.7	
Miscellaneous Administrator	3	5	7	5	-	-	1	4	13	25	-	24	8.0	
Hospital, Unit Administrator	3	5	1	1	1	-	-	-	-	-	-	5	1.7	
Health Centre Administrator	22	36	104	75	2	3	14	64	9	17	3	157	52.3	
Practice Administrator	1	2	4	3	-	-	3	14	1	2	-	9	3.0	
Secretary, Receptionist	9	15	3	2	-	-	1	4	6	12	5	24	8.0	
Clinic clerk, Clerk	16	26	11	8	1	-	-	-	17	33	3	48	16.0	
Nurse, H.V., Nursing Officer	3	5	2	1	-	-	1	4	1	2	1	8	2.7	
Cleaner, Caretaker	-	-	-	-	-	-	-	-	4	8	-	4	1.3	
Other	-	-	-	-	-	1	1	4	-	-	-	2	0.7	
Total	61	100	138	100	8	6	22	100	52	100	13	300*	100	

* Excludes 238 health centres where there is no committee

TABLE 84

Role on the house committee (where it exists) of person responsible for day-to-day administration in centres where two persons are responsible.

Title	Role on house committee									
	Member		Secretary	Chairman	Other	No role		No answer	Total	
	No.	%				No.	%		No.	%
Sector Administrator	1	5	1	-	1	2	12	-	5	8
Community Services Administrator	5	26	4	-	-	2	12	-	11	17
Miscellaneous Administrator	-	-	5	1	2	5	29	-	13	20
Hospital, Unit Administrator	1	5	-	-	1	-	-	-	2	3
Health Centre Administrator	3	16	3	1	-	-	-	-	7	11
Practice Administrator	-	-	-	-	1	-	-	-	1	2
Secretary, Receptionist	3	16	1	-	-	1	6	1	6	9
Clinic clerk, clerk	2	11	-	-	-	2	12	1	5	8
Nurse, H.V., Nursing Officer	2	11	-	-	-	1	6	-	3	5
Domestic supervisor	-	-	-	-	-	2	12	6	8	12
Cleaner, caretaker	2	11	-	-	-	2	12	-	4	6
Total	19	100	14	2	5	17	100	8	65	100

TABLE 85

Role on house committee (where it exists) of person classified by title, responsible for day-to-day administration in centres where three persons are responsible.

Title	Role on house committee				
	Member	Secretary	Other	No role	Total
Sector Administrator	2	-	-	-	2
Miscellaneous Administrator	2	-	1	-	3
Health centre Administrator	-	1	-	1	2
Practice Administrator	-	1	-	1	2
Clinic Clerk, Clerk	1	1	-	-	2
Total	5	3	1	2	11

TABLE 86

Employment category of those responsible for the day-to-day administration of health centres by total number of general practitioners practising from the health centre for one person centres.

Employment category	Total number of general practitioners working from centre									
	0	1 - 4		5 - 8		9 - 12		13 or more		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
A	-	70	30	79	38	31	41	7	35	187	35
B	-	10	4	10	5	6	8	3	15	29	5
C	1	26	11	35	17	14	19	7	35	83	15
D	1	41	18	27	13	6	8	-	-	75	14
E	-	15	7	13	6	5	7	2	10	35	7
F	3	46	20	28	13	6	8	1	5	84	16
G, H	-	16	7	14	7	5	7	-	-	35	7
I	-	6	3	2	1	2	3	-	-	10	2
TOTAL	5	230	100	208	100	75	100	20	100	538	100

TABLE 87

Employment category of those responsible for the day-to-day administration of health centres by 'complexity' of the health centres for one person centres.

Employment category	'Complexity' of the health centre													
	1 - 4		5 - 8		9 - 12		13 - 16		17 - 20		21 - 24		25 or more		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
A	10	28	51	32	46	33	39	36	19	35	16	67	6	40	187	35
B	-	-	7	4	8	6	6	6	5	9	1	4	2	13	29	5
C	3	8	17	11	18	13	22	21	13	24	4	17	6	40	83	15
D	9	24	27	17	23	16	11	10	5	9	-	-	-	-	75	14
E	4	11	13	8	8	6	7	7	3	6	-	-	-	-	35	7
F	7	19	31	19	28	20	11	10	5	9	2	8	-	-	84	16
G, H	3	8	10	6	8	6	9	8	3	6	1	4	1	7	35	7
I	1	3	5	3	1	1	2	2	1	2	-	-	-	-	10	2
TOTAL	37	100	161	100	140	100	107	100	54	100	24	100	15	100	538	100

TABLE 88

Employment category of those responsible for the day-to-day administration of health centres by total number of general practitioners practising from the health centre for two person centres.

Employment category	Total number of general practitioners working from centre							
	1 - 4		5 - 8		9 - 12		13 or more	Total	
	No.	%	No.	%	No.	%	No.	No.	%
No answer	7	5	3	3	-	-	-	10	4
A	28	22	16	15	3	17	2	49	18
B	-	-	1	1	1	6	-	2	1
C	9	7	15	14	-	-	-	24	9
D	30	23	24	22	5	28	1	60	23
E	11	8	11	10	1	6	1	24	9
F	34	26	27	25	4	22	6	71	27
G, H	8	6	6	6	3	17	-	17	6
I	3	2	5	5	1	6	-	9	3
TOTAL	130	100	108	100	18	100	10	266	100

TABLE 89

Employment category of those responsible for the day-to-day administration of health centres by 'complexity' of the health centres for two person centres.

Employment category	'Complexity' of the health centre											
	1 - 4		5 - 8		9 - 12		13 - 16		17 - 20		21 or more	Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	No.	%
No answer	3	25	4	4	1	1	1	3	1	6	-	10	4
A	-	-	20	20	18	20	6	15	3	19	2	49	18
B	-	-	-	-	1	1	-	-	1	6	-	2	1
C	-	-	9	9	9	10	4	10	2	13	-	24	9
D	2	17	24	24	19	21	13	33	1	6	1	60	23
E	1	8	11	11	7	8	4	10	-	-	1	24	9
F	4	33	23	23	26	28	8	20	7	44	3	71	27
G	2	17	6	6	6	7	3	8	-	-	-	17	6
I	-	-	1	1	5	5	1	3	1	6	1	9	3
TOTAL	12	100	98	100	92	100	40	100	16	100	8	266	100

TABLE 90

Employment category of those responsible for the day-to-day administration of health centres by total number of general practitioners practising from the health centre for three person centres.

Employment category	Total number of general practitioners working from centre									
	1 - 4		5 - 8		9 - 12		13 or more	Total	
	No.	%	No.	%	No.	%	No.	No.	%
No answer	-	-	1	3	-	-	-	1	1
A	3	7	2	7	7	39	3	15	15
B	-	-	1	3	-	-	-	1	1
C	2	5	-	-	-	-	-	2	2
D	24	57	6	20	2	11	2	34	34
E	-	-	4	13	3	17	-	7	7
F	7	17	9	30	2	11	4	22	22
G, H	2	5	5	17	3	17	-	10	10
I	4	10	2	7	1	6	-	7	7
TOTAL	42	100	30	100	18	100	9	99	100

TABLE 91

Employment category of those responsible for the day-to-day administration of health centres by 'complexity' of the health centres for three person centres.

Employment category	'Complexity' of the health centre											
	1 - 4	5 - 8		9 - 12		13 - 16		17 - 20		21 or more	Total	
	No.	No.	%	No.	%	No.	%	No.	%	No.	No.	%
No answer	-	-	-	1	4	-	-	-	-	-	1	1
A	2	1	4	-	-	3	17	6	40	3	15	15
B	-	-	-	-	-	1	6	-	-	-	1	1
C	-	2	8	-	-	-	-	-	-	-	2	2
D	2	11	46	14	58	3	17	3	20	1	34	34
E	-	1	4	1	4	2	11	2	13	1	7	7
F	1	6	25	4	17	7	39	2	13	2	22	22
G, H	2	1	4	3	13	2	11	-	-	2	10	10
I	2	2	8	1	4	-	-	2	13	-	7	7
TOTAL	9	24	100	24	100	18	100	15	100	9	99	100

TABLE 92

Proportions of administrators in employment category A, B and C on salary grades of GAA or above according to the total number of general practitioners working from the centre and by the number of administrators listed as responsible for its day-to-day administration

Employment category	No. of persons involved in administration	Total number of general practitioners in the centre				
		1 - 4	5 - 8	9 - 12	13 and more	Total
A	1	13/70	30/79	25/31	4/7	72/187
	2	1/28	2/16	0/3	0/2	3/49
	3	0/3	0/2	0/7	1/3	1/15
B	1	7/10	7/10	5/6	3/3	22/29
	2	0/0	1/1	1/1	0/0	2/2
	3	0/0	0/1	0/0	0/0	0/1
C	1	15/26	25/35	12/14	6/7	58/83*
	2	6/9	10/15	0/0	0/0	16/24
	3	2/2	0/0	0/0	0/0	2/2
A, B, C	1	35/106	62/124	42/51	13/17	152/299*
	2	7/37	13/32	1/4	0/2	21/75
	3	2/5	0/3	0/7	1/3	3/18

* This total includes one centre where no general practitioners were working at all.

Note that the entries in the table take the following form, $^{P}/_{Q}$, where P is the number of administrators in the category under consideration on salary grades GAA or above (i.e. SAA or PAA) and Q is the total number of administrators in the category.

TABLE 93

Proportions of administrators in employment category A, B, and C on salary grades of GAA or above according to the complexity of the centres and by the number of administrators listed as responsible for its day-to-day administration

Employment category	No. of persons involved in administration	Complexity of the centre *							
		1 - 4	5 - 8	9 - 12	13 - 16	17 - 20	21 - 24	25 or more	Total
A	1	$^{2}/_{10}$	$^{8}/_{51}$	$^{13}/_{46}$	$^{21}/_{39}$	$^{13}/_{19}$	$^{12}/_{16}$	$^{3}/_{6}$	$^{72}/_{187}$
	2	$^{0}/_{0}$	$^{0}/_{20}$	$^{2}/_{18}$	$^{1}/_{6}$	$^{0}/_{3}$	$^{0}/_{1}$	$^{0}/_{1}$	$^{3}/_{49}$
	3	$^{0}/_{2}$	$^{0}/_{1}$	$^{0}/_{0}$	$^{0}/_{3}$	$^{0}/_{6}$	$^{1}/_{3}$	$^{0}/_{0}$	$^{1}/_{15}$
B	1	$^{0}/_{0}$	$^{4}/_{7}$	$^{8}/_{8}$	$^{3}/_{6}$	$^{4}/_{5}$	$^{1}/_{1}$	$^{2}/_{2}$	$^{22}/_{29}$
	2	$^{0}/_{0}$	$^{0}/_{0}$	$^{1}/_{1}$	$^{0}/_{0}$	$^{1}/_{1}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{2}/_{2}$
	3	$^{0}/_{0}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{0}/_{1}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{0}/_{1}$
C	1	$^{0}/_{3}$	$^{12}/_{17}$	$^{15}/_{18}$	$^{12}/_{22}$	$^{10}/_{13}$	$^{3}/_{4}$	$^{6}/_{6}$	$^{58}/_{83}$
	2	$^{0}/_{0}$	$^{5}/_{9}$	$^{7}/_{9}$	$^{2}/_{4}$	$^{2}/_{2}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{16}/_{24}$
	3	$^{0}/_{0}$	$^{2}/_{2}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{0}/_{0}$	$^{2}/_{2}$
A, B, C	1	$^{2}/_{13}$	$^{24}/_{75}$	$^{36}/_{72}$	$^{36}/_{67}$	$^{27}/_{37}$	$^{16}/_{21}$	$^{11}/_{14}$	$^{152}/_{299}$
	2	$^{0}/_{0}$	$^{5}/_{29}$	$^{10}/_{28}$	$^{3}/_{10}$	$^{3}/_{6}$	$^{0}/_{1}$	$^{0}/_{1}$	$^{21}/_{75}$
	3	$^{0}/_{2}$	$^{2}/_{3}$	$^{0}/_{0}$	$^{0}/_{4}$	$^{0}/_{6}$	$^{1}/_{3}$	$^{0}/_{0}$	$^{3}/_{18}$

* See page 47

Note that the entries in the table take the following form, $^{P}/_{Q}$, where P is the number of administrators in the category under consideration on salary grades GAA or above (i.e. SAA or PAA) and Q is the total number of administrators in the category.

GLOSSARY

AMO	Area Medical Officer
CO	Clerical Officer
DCP	District Community Physician
FPC	Family Practitioner Committee
GAA	General Administrative Assistant
GP	General Medical Practitioner
HCO	Higher Clerical Officer
HD	Health District
HV	Health Visitor
LA	Local Authority
PAA	Principal Administrative Assistant
SAA	Senior Administrative Assistant
SDA	Single District Area